

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11023 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11015

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>PENNSYLVANIA</u> b. COUNTY <u>Dauphin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Parkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARRISBURG</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. 111 1 Mi. South of Parkton</u>		d. STREET ADDRESS <u>2911 N. 2nd St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Celia</u> Middle <u>ABRAMS</u> Last <u></u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>24</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25, 1909</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Harrisburg, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Levi</u>		14. MOTHER'S MAIDEN NAME <u>Hanna Block</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>----</u>	
17. INFORMANT <u>R. J. Reese</u>		<u>911 N. Second St., Harrisburg, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BURNED TO DEATH</u> 819X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9/24</u> 19 <u>61</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 116</u>	
20f. (City or town) <u>BALTO</u>		(State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>G. M. France</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9/24/61</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 27, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Beth El Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Paxtang, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Kortenstein, New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 26 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hous</u>			

11083 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11083

NAME OF DECEASED WILLIAM J. BAKER		SEX Male		AGE 65	
DATE OF DEATH April 1, 1961		PLACE OF DEATH Home		CITY Baltimore	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		LOCALITY Baltimore, Maryland	
SIGNATURE OF EXAMINER [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	
SIGNATURE OF WITNESS [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	
SIGNATURE OF SECOND WITNESS [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	
SIGNATURE OF THIRD WITNESS [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	
SIGNATURE OF FOURTH WITNESS [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	
SIGNATURE OF FIFTH WITNESS [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	
SIGNATURE OF SIXTH WITNESS [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	
SIGNATURE OF SEVENTH WITNESS [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	
SIGNATURE OF EIGHTH WITNESS [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	
SIGNATURE OF NINTH WITNESS [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	
SIGNATURE OF TENTH WITNESS [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	
SIGNATURE OF ELEVENTH WITNESS [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	
SIGNATURE OF TWELFTH WITNESS [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	
SIGNATURE OF THIRTEENTH WITNESS [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	
SIGNATURE OF FOURTEENTH WITNESS [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	
SIGNATURE OF FIFTEENTH WITNESS [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	
SIGNATURE OF SIXTEENTH WITNESS [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	
SIGNATURE OF SEVENTEENTH WITNESS [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	
SIGNATURE OF EIGHTEENTH WITNESS [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	
SIGNATURE OF NINETEENTH WITNESS [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	
SIGNATURE OF TWENTIETH WITNESS [Signature]		DATE April 1, 1961		PLACE Baltimore, Maryland	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9865

CERTIFICATE OF DEATH

Reg. Dist. No.

09854

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOCK RAVEN</u>				c. LENGTH OF STAY IN 1b <u>2 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1639 COTTAGE LANE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>KLEMENTYNA</u> Middle <u>ADAMS</u> Last <u>KA</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 23 - 1882</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA POLAND</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>			
11. BIRTHPLACE (State or foreign country) <u>POLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA POLAND</u>			
13. FATHER'S NAME <u>JOZEF OLSZEWSKI</u>				14. MOTHER'S MAIDEN NAME <u>ANNA PAJENSKA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>DR BRUNO ADAMSKI</u>				18. Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>arteriosclerotic Cardio Vascular renal disease.</u> (b) <u>Septamyelaria</u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Mar</u> , 19 <u>61</u> , to <u>Sept 3</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Apr 3</u> , 19 <u>61</u> , and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold H Burns</u> M.D. <u>8106 Hayford Rd.</u>				ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>9-6-61</u>			
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Sept 7, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DOLANEY VALLEY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS F EVANS & SON</u>				24. REC'D BY REGISTRAR DATE <u>SEP 7 '61</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>							

MEDICAL CERTIFICATION

(M)

(1)

Chas E. Farnsworth 8809 Highland Ave
Baltimore, Md

1-2-81

1-2-81

1-2-81

1-2-81

1-2-81

1-2-81

1-2-81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9866

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Res. Inst. name and address) a. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN 1b 33 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 PLAYFIELD Rd		e. STREET ADDRESS 13 PLAYFIELD Rd	
3. NAME OF DECEASED (Type or print) LAURA JULIA ANGEL		4. DATE OF DEATH 9/9/61 Day 19 Year 19	
5. SEX FEM.	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/24/1890
9. AGE (In years last birthday) 71 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GOTTLIEB KILCHENMAN		14. MOTHER'S MAIDEN NAME ELIZABETH KREBS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-10-3145B	
17. INFORMANT LUTHER C. ANGEL		Address AS #2 ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA of Colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-5-59 , 19 59 , to 9-5-61 , 19 61 , and that death occurred at 6 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Jack E Collins M.D.		ADDRESS (Street, city or town, state) 2 Keir Lp DATE SIGNED 9-11-61	
PHYSICIAN'S NAME (Type) Jack E Collins		Balt 22	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/12/61	22c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE	22d. LOCATION (City, town, or county) (State) DORSEY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Walter Andrew Bradley, Dundalk, Md.		24a. REC'D BY REGISTRAR DATE SEP 13 '61	
24b. REGISTRAR'S SIGNATURE Andrew S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11028

Reg. Dist. No.

19856

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE PENNSYLVANIA b. COUNTY Dauphin			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Parkton		c. LENGTH OF STAY IN 1b Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARRISBURG		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 111 1 Mi. South of Parkton				d. STREET ADDRESS 2715 N. 4th St.			
3. NAME OF DECEASED (Type or print) First Lewis Middle M. ARONSON Last				4. DATE OF DEATH Month Sept. Day 24 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 13, 1902	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Oil Distributor		11. BIRTHPLACE (State or foreign country) Harrisburg, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Julius Aronson				14. MOTHER'S MAIDEN NAME Helen Mihls			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 171 28 1443		17. INFORMANT Richard J. Reese		911 N. Second St., Harrisburg, Penna.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burned to death 819X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile accident					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 9/24/61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 111		20f. (City or town) (County) (State) Balto. Ind	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE A. M. France				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) A. M. FRANCE				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		9/24/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 27, 1961		22c. NAME OF CEMETERY OR CREMATORY Beth El Cemetery		22d. LOCATION (City, town, or county) (State) Paxtang, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Isaac Hartenstein, New Freedom, Pa.				24a. REC'D BY REGISTRAR DATE SEP 26 '61		24b. REGISTRAR'S SIGNATURE Arthur S. France	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11029

Reg. Dist. No. 09857

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Parkton</u> c. LENGTH OF STAY IN 1b <u>Minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. 111 1 Mi. South of Parkton</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>PENNSYLVANIA</u> b. COUNTY <u>Dauphin</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrisburg</u> d. STREET ADDRESS <u>2715 N. 4th St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>LILLIAN ARNOLD</u> First Middle Last				4. DATE OF DEATH <u>Sept. 24 1961</u> Month Day Year					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 20, 1904</u>		9. AGE (In years last birthday) <u>57</u> yrs. 10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Harrisburg, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Levi</u>				14. MOTHER'S MAIDEN NAME <u>Hanna Block</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>199 34 8378</u>				17. INFORMANT <u>R. J. Reese</u> <u>911 N. Second St., Harrisburg, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burned to death</u> <u>819X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____									
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident</u> <u>Station wagon crashed into bridge abutment</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>4</u> p. m. <u>9/24 1961</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 111</u>		20f. (City or town) (County) (State) <u>DAUPHIN MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>A. M. France</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>9/24/61</u>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Sept 27, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Beth El Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Paxtang, Penna.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR <u>SEP 26 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. France</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose it in a separate envelope, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

028



Form with multiple sections for medical examination and death certification, including fields for name, date, time, and cause of death. The form is oriented horizontally but contains vertical text labels for various fields.

NAME: [illegible]
DATE: [illegible]
TIME: [illegible]
PLACE: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

Vertical text on the right margin, possibly a date or reference number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed in by the funeral director. After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9867

Item 2 Film 6292 9/18/61 iwk

09858

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 29, Md.		
c. LENGTH OF STAY IN 1b <u>30 yrs</u>			d. STREET ADDRESS <u>353 Maryland Road</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove State Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>HATTIE</u> First <u>M</u> Middle <u>ARRINGTON</u> Last			4. DATE OF DEATH <u>9/9</u> 19 <u>61</u> Month <u>9</u> Day <u>9</u> Year		
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>MAY 28 1880</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GEORGE STRECKER</u>			
14. MOTHER'S MAIDEN NAME <u>ALICE DAY</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Records Spring Grove State Hospital</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> 422.1 DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>—</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Senile changes osteoarthritis in both knees for 3 yrs</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year <u>9/9/61</u> Hour a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>		21. I certify that (I) (this hospital) attended the deceased from <u>8/14/61</u> 19 <u>31</u> to <u>9/9/61</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>9/9/61</u> 19 <u>61</u> , and that death occurred at <u>9:55 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Bruno Radauskas</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/9/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>BRUNO RADAUSKAS</u>		22d. ADDRESS <u>Spring Grove St Hosp. Catonsville Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/12/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Logdon Park</u>	
23d. LOCATION (City, town or county) <u>Balto. Md.</u>		(State) <u>—</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>G. Truman Schwal</u> ADDRESS <u>3512 Frederick Ave. (29)</u>		25a. REC'D BY REGISTRAR <u>—</u> DATE <u>SEP 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9868

CERTIFICATE OF DEATH

09859

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARBUTUS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARBUTUS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4216 KENSINGTON RD.			d. STREET ADDRESS 4216 KENSINGTON RD.		
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD ROLAND AUER			4. DATE OF DEATH Month Day Year SEPT. 1 1961		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 17, 1891		9. AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Record Clerk			10b. KIND OF BUSINESS OR INDUSTRY Court House		11. BIRTHPLACE (County & State, or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME William T. AUER			14. MOTHER'S MAIDEN NAME Sarah Wells		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16. SOCIAL SECURITY NO. W.W.I		
17. INFORMANT W. L. AUER - 4216 Kensington Rd.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 20 min.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (the hospital) attended the deceased from April 2, 1961 to Sept 1, 1961 , that (I) (we) last saw the deceased alive on Aug. 19, 1961 , and that death occurred at 10:20 AM , from the causes and on the date stated above.					
22a. SIGNATURE John F. Schaefer		22b. DATE 9-3-61		22c. PHYSICIAN'S NAME (Type) JOHN F. SCHAEFER	
22d. ADDRESS 401 Randon Rd. Balto. 29 Md.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-5-61		23c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.	
23d. LOCATION (City, town or county) Balto.		23e. (State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Forley - Cavanaugh & F.H.		24a. ADDRESS Catonville, Md.		25a. REC'D BY REGISTRAR SEP 8 '61	
25b. REGISTRAR'S SIGNATURE Orlino L. Hume					

02880

2388

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

[Faint handwritten text at the bottom of the page, including what appears to be a signature and date.]

CERTIFICATE OF DEATH

9869

09860

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution, Record in separate admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		2103-2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Presbyterian Home				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emily Baechtel		First Middle Last		4. DATE OF DEATH September 12 1961		Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 26, 1970		9. AGE (In years last birthday) yrs. 90	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charlee E. Baechtel		14. MOTHER'S MAIDEN NAME Sarah J. McDowell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. T.E. Elliott		Address Presbyterian Home	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - Hypostatic 422 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 48 hrs years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (Physician) attended the deceased from January 1959 to Sept. 12, 1961, that (I) (X) saw the deceased alive on September 6, 1961, and that death occurred at 7 p.m. from the causes and on the date stated above							
22a. SIGNATURE S. J. Venable M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE Sept. 15, 1961	
22c. PHYSICIAN'S NAME (Type) Dr. S.J. Venable, Jr.				22d. ADDRESS 7215 York Road, Baltimore 12, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-15-61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill		23d. LOCATION (City, town or county) (State) Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place				25a. REC'D BY REGISTRAR DATE SEP 18 '61		25b. REGISTRAR'S SIGNATURE Arthur S. H... ..	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [redacted] 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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(1)

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September 6, 1961

Mr. J. E. ...

Com. of ...
and ...

January 2, 1961

Sept. 12, 1961

Sept. 12, 1961

Sept. 12, 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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3
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9870
CERTIFICATE OF DEATH
09861

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>214 Third Avenue</u>				d. STREET ADDRESS <u>214 Third Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>H.</u> Last <u>Barker</u>				4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 8, 1880</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>81</u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Edelen Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Anne Arundle, County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>George Barker</u>				14. MOTHER'S MAIDEN NAME <u>Eletha ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Mr. James M. Barker-412 Fifth Ave. S.E. Glen.</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cerebrovascular accident</u> 331X DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Old age (83)</u> DUE TO (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 15 61</u> to <u>Sept. 13 61</u> that (I) (we) last saw the deceased alive on <u>Sept 13 19 61</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Henry Armanax</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept. 13, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY ARMANAX</u>				22d. ADDRESS <u>1934 Wilkens Hve. Balto. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-16-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tucker & Sons North + Pennsylvania-Balton Md.</u>				25a. REC'D BY REGISTRAR <u>SEP 15 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

UNITED STATES OF AMERICA

3870

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1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9871 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09862

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Paper Mill Rd. near Old York Rd.				d. STREET ADDRESS Paper Mill Rd. near Old York Rd.			
3. NAME OF DECEASED (Type or print) BURNIE EUGENE BARNETT				4. DATE OF DEATH Month Sept. Day 27 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 13, 1887	
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer- retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Barrett				14. MOTHER'S MAIDEN NAME Martha Martin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 214-03-0226		17. INFORMANT Family Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH Sudden 10 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. O'Donnell		Address (Street, city, town, or county)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/27/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 1, 1961		22c. NAME OF CEMETERY OR CREMATORY Poplar Grove Cemetery		22d. LOCATION (City, town, or country) (State) Cockeysville, Md.	
23. FUNERAL DIRECTOR John Burns' Sons, Towson, Md.				24a. REC'D BY REGISTRAR DATE OCT 5 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	



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John W. Love, Jr., 1902, 1903, 1904, 1905, 1906, 1907, 1908, 1909, 1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582,

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James C. Thompson
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Family Records

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Journal of Management Education 32(1)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9872

Reg. Dist. No. 09863

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>			
c. LENGTH OF STAY IN 1b <u>eight days</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Convalescent Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Shelby</u> Last <u>Basford</u>				4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1961</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 7, 1868</u>		9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>breakman B & O</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Co. Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George BASFORD</u>				14. MOTHER'S MAIDEN NAME <u>Laura ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Mahelle Smith</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>42.01</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>10 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>18 Sept</u> , 19 <u>61</u> , to <u>28 Sept</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>27 Sept</u> , 19 <u>61</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles F O'Donnell</u> M.D. <u>2501 York Rd #4 Md</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>9/28/61</u>			
PHYSICIAN'S NAME (Type) <u>Charles F O'Donnell M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/30/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Garage Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Garage, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witt Donaldson</u> ADDRESS <u>Laurel Md</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 4 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9873											
Item 2 Film G297 10/2/61 mh 09864											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Maryland f. COUNTY Carroll							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN lb 10 mth ldy				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS Upper Beckleysville Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jennie Middle Baublitz Last Baublitz				4. DATE OF DEATH Month September Day 22 Year 1961							
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1872		9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO. unknown				17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic cardiovascular disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Infected decubitus ulcers 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (X) (this hospital) attended the deceased from Nov. 21, 1960 to Sept. 22, 1961 , that (I) (we) last saw the deceased alive on Sept. 22, 1961 , and that death occurred at 3:25 p.m. from the causes and on the date stated above. 22a. SIGNATURE Stella Wachslar M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 9-22-61 22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9-25-61 23c. NAME OF CEMETERY OR CREMATORY Grace Reem 23d. LOCATION (City, town or county) (State) Balto co Md 24. FUNERAL DIRECTOR'S SIGNATURE Chpton-ELINE-Hampstead Md ADDRESS 25a. REC'D BY REGISTRAR SEP 26 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hines											

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1 FOR STATE HEALTH DEPT.

TO DEP. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the Director, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 9874 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Retiree () or (in admission)) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6417 Colesville Road - Hyattsville, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 6417 Colesville Road 1664-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna		First Middle Last Baumgartner		4. DATE OF DEATH Month Day Year September 21, 1961			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1883	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Huber				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 904-5 IMMEDIATE CAUSE (a) Acute Cardiac failure DUE TO (b) Bronchial Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Accidental						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) On 9-13-61 pt. slipped to floor sustaining a comminuted frac. of the neck of left femur					
20c. TIME OF INJURY Month, Day, Year 7:05 a.m. 9-13 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) (County) (State) Catonsville 28, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Geo. M. Kieffer		EXAMINER'S NAME (Type) George M. Kieffer, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9-21-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 25, 1961		22c. NAME OF CEMETERY OR PLACE OF BURIAL George Washington		22d. LOCATION (City, town, or country) (State) Hyattsville Md	
23. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville Md				24a. REC'D BY REGISTRAR DATE SEP 25 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9875
CERTIFICATE OF DEATH
09866

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Pikesville</u> c. LENGTH OF STAY IN 1b <u>1 1/2 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Angelwing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>3401-42708 Southern Ave</u> d. STREET ADDRESS <u>6811 Campbell Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Blanche Eloria Bayless</u>		4. DATE OF DEATH <u>Sept 26 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 27 1876</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GAS & ELECTRIC</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hermon Mendenhall</u>		14. MOTHER'S MAIDEN NAME <u>Annie Clarke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>T. W. Katerkamp</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X (1) - Broncho - Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(2) Cerebral Hemorrhage</u> DUE TO (c) <u>(3) Hypertensive Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 days</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 24</u> 19 <u>61</u> to <u>Sept. 26</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Sept. 24</u> 19 <u>61</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Earl L. Chambers</u> M.D.		22b. DATE SIGNED <u>Sept 26, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Earl L. Chambers - M.D.</u>		22d. ADDRESS <u>4108 Liberty Hg Balto - 7 ml - 9-26-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9/28/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT Cem</u>	23d. LOCATION (City, town or county) (State) <u>BALTIMORE MD</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. RUCK</u>		25a. REC'D BY REGISTRAR <u>SEP 29 '61</u>	
ADDRESS <u>5305 HARFORD Rd.</u>		25b. REGISTRAR'S SIGNATURE <u>C. Shum & Knaud</u>	

22820

1529

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9876

CERTIFICATE OF DEATH

Reg. Dist. No. 09867

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6900 Beech Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Katherine C. Beitman		4. DATE OF DEATH Month Day Year Sept. 25, 1961 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1893
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookbinder		10b. KIND OF BUSINESS OR INDUSTRY Printing	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Courtney		14. MOTHER'S MAIDEN NAME Catherine Broderick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-05-6732	
17. INFORMANT Mrs. C. Melissa Marcin, 4156 Pimlico Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH 2 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-18 , 19 61 , to 9-25 , 19 61 , that I last saw the deceased alive on 9-22 , 19 61 , and that death occurred at 9:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul G. Mueller		ADDRESS (Street, city or town, state) DATE SIGNED 6411 Belair Rd. Balt (Md) 9/25/61	
PHYSICIAN'S NAME (Type) Paul G. Mueller, M.D.		6411 Belair Road	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/61	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Vernon Lewis		ADDRESS 4611 Park Heights, Balto. Md.	
24a. REC'D BY REGISTRAR SEP 26 '61		DATE	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

— 2 —

$$r = \frac{1}{2} \left(\frac{1}{\lambda_1} + \frac{1}{\lambda_2} \right)$$

• *M. erciliae*

Figure 1

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9877 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09868

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkton		c. LENGTH OF STAY IN 1b Towson		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkton		d. STREET ADDRESS Hillcrest Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Clarence William Belt		4. DATE OF DEATH Month 9 Day 27 Year 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 4, 1915		9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months 4 Days 6		11. IF UNDER 24 HRS. Hours 1 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lt. Balto. Co. Fire Dept. Fire Suppression		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Clarence Alvin Belt		14. MOTHER'S MAIDEN NAME Sadie M. Livingston		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 216-07-5717		17. INFORMANT Family Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) myocardial infarct DUE TO (c) 4201 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE William V. Lovitt, Jr. M.D. EXAMINER'S NAME (Type) WILLIAM V. LOVITT, Jr., M.D. DATE SIGNED 9-27-61 XXXXXXXXXX Address (Street, city, town, or county)																	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Sept. 30, 1961				22c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial				22d. LOCATION (City, town, or country) (State) Cockeysville, Maryland					
23. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland								24a. REC'D BY REGISTRAR DATE OCT 5 '61				24b. REGISTRAR'S SIGNATURE Arthur L. Hanna					

MEDICAL CERTIFICATION

[illegible]

• 1944 •

1921

[Turner-Alvin Bell]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

9878

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09869

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> <i>Rosewood State Training School</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings Mills</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rosewood State Training School</i>		d. STREET ADDRESS <i>5013 Sunset Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Jeffrey</i> Middle <i>Berg</i> Last <i>Berg</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>13</i> Year <i>1961</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-3-57</i>
9. AGE (In years last birthday) <i>4</i> yrs.		IF UNDER 1 YEAR Months <i>4</i> Days <i>13</i> Hours <i>13</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Myron Berg</i>		14. MOTHER'S MAIDEN NAME <i>Pauline Pearl Berg</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Hospital Records</i>		Address <i>Hospital Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Severe Enterocolitis</i> 57101 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Dehydration</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Brain Syndrome associated E Mongolism with severe mental deficiency</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>8-11</i> , 19 <i>60</i> , to <i>9-13</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>9-13</i> , 19 <i>61</i> , and that death occurred at <i>1 P.M.</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Harry M. Butler</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9-14-1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Woodsdale</i>		23d. LOCATION (City, town, or county) (State) <i>Balto</i> <i>Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Levine</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 15 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles E. Harris</i>			

1988

CERTIFICATE OF DEATH

0278

M

1

CHIEF OF POLICE

1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
9879 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09870										
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex (21) c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2223 Corcsia Road					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex (21) d. STREET ADDRESS 2223 Corcsia Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ALFRED E. BLACKMORE					4. DATE OF DEATH September 24, 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 3, 1901		9. AGE (in years last birthday) 60 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oxygen Operator					10b. KIND OF BUSINESS OR INDUSTRY Gas Bottling Co.		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Chauncey Blackmore					14. MOTHER'S MAIDEN NAME Edna Watson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) --					16. SOCIAL SECURITY NO. 134-09-0626		17. INFORMANT Marie Blackmore Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42011 DUE TO Cornary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 30 min										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 9-25-61 ACTUAL SIGNATURE SA-L C Collins EXAMINER'S NAME (Type) SA-L C Collins Address (Street, city, town, or county)										
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9/25/61		22c. NAME OF CEMETERY OR CREMATORY Schalderer Funeral Home Spring Forest Cemetery		22d. LOCATION (City, town, or country) (State) Binghamton, New York				
23. FUNERAL DIRECTOR James E. Bruzdinski ADDRESS 1407 Eastern Ave.					24a. REC'D BY REGISTRAR SEP 26 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

(M)

(I)

(M)

(1)

Baltimore

Essex (21)

2223 Corcoran Road

ALBERT E. ELACHOWICZ

2223 Corcoran Road

September 20, 1961

Info

State

in

March 3, 1961

60

Cyren Operator

San Hoteling Co.

New York

U.S.A.

Johnny Elachowicz

Edna Watson

134-03-0885

White Elachowicz

and

Johnny Elachowicz

John C. Collins

also

Report

Baltimore Funeral Home
Spring Street Cemetery

Baltimore, New York

James H. Hennessey, 120 Madison Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9880

09871

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY in 1b <u>1mth13dys</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u> <u>1224-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove St Hospital</u>				d. STREET ADDRESS <u>875 Ontario St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Winfield Jackson Botts</u>				4. DATE OF DEATH Month <u>9</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-1-74</u>		9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown ELECTRICIAN RETIRED</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Hartford Co, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>WINFIELD GOLDSMITH BOTT</u> <u>unknown</u>			14. MOTHER'S MAIDEN NAME <u>MALISSA GARDNER</u> <u>unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Charlotte, N.C.</u> <u>Mrs. Josephine Ricketts 929 Scalp Bar Rd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> <u>442X</u> DUE TO (b) <u>arteriosclerotic heart & kidney disease long standing</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <u>generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>malnutrition</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				22b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>8-1-61</u> to <u>9-15</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>9-14</u> , 19 <u>61</u> , and that death occurred at <u>7:40</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Stella Wachler</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>		22b. DATE SIGNED <u>9-15-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT. 18, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GROVE CEM.</u>		23d. LOCATION (City, town or county) (State) <u>ABERDEEN MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>				ADDRESS <u>Harre de Grace, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 19 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

0880

0880

M

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Winnipeg, Manitoba
The Winnipeg Tribune

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9881						09872					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY BALTO. MARYLAND						a. STATE MD. b. COUNTY BALTO.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 131 NEWBURG AVE						d. STREET ADDRESS 131 NEWBURG AVE.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last FRANCES TERESIA BROOKS						Month Day Year SEPT. 17 1961					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 1, 1888		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER						10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOSEPH GESSNER						14. MOTHER'S MAIDEN NAME ELIZABETH SCHMITT					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)						16. SOCIAL SECURITY NO. —		17. INFORMANT Address Raymond E. Brooks - 131 Newburg Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO (b) Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Sudden 25 years 77											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Posterior Myocardial Infarction Feb. 1961											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Balto.		20g. (County) Ind.		20h. (State) Ind.	
21. I certify that (I) (this hospital) attended the deceased from 6/3 to 9/17 , 19 61 that (I) (we) last saw the deceased alive on 9/14 , 19 61 , and that death occurred at 4:30 PM from the causes and on the date stated above.											
22a. SIGNATURE Elmer W. Johnson						22b. DATE SIGNED 9/19/61					
22c. PHYSICIAN'S NAME (Type) Elmer W. Johnson						22d. ADDRESS 3432 E. Enoch Ave. Balt. Md 29 NW					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-21-61		23c. NAME OF CEMETERY OR CREMATORY Catholic Cem.		23d. LOCATION (City, town or county) Balto.		23e. (State) Ind.			
24. FUNERAL DIRECTOR'S SIGNATURE Earley Cunningham B. H. - Catonsville, Md.						ADDRESS Catonsville, Md.		25a. REC'D BY REGISTRAR SEP 25 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

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FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Life pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9882 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09873

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 33 days		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Vetans Administration Hospital			e. STREET ADDRESS 5415 Race Road		
3. NAME OF DECEASED (Type or print) MELVIN A. BROOKS			4. DATE OF DEATH September 22 19 61		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 28, 1920		9. AGE (In years last birthday) 41 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Worker		10b. KIND OF BUSINESS OR INDUSTRY Concrete Pipe Co.		11. BIRTHPLACE (State or foreign country) Elkridge, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Herman P. Brooks		
14. MOTHER'S MAIDEN NAME Mary MacIntosh			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-11		
16. SOCIAL SECURITY NO. 217-03-5510			17. INFORMANT Clinical Records VA Hospital		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 491X Pulmonary Embolus DUE TO Branch pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Subdural hematoma			INTERVAL BETWEEN ONSET AND DEATH 10 min 3 days		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Sack & Collins			DATE SIGNED 9-23-61		
EXAMINER'S NAME (Type) Sack & Collins			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 9-27-61		
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery			22d. LOCATION (City, town, or country) (State) Baltimore Maryland		
23. FUNERAL DIRECTOR Elroy O. Wilson Funeral Home			24a. REC'D BY REGISTRAR Balto 17, Md.		
24b. REGISTRAR'S SIGNATURE SEP 27 '61			24c. REGISTRAR'S SIGNATURE Arthur L. House		

MEDICAL CERTIFICATION

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1. Name of deceased
2. Date of death
3. Place of death
4. Cause of death
5. Manner of death
6. Signature of physician
7. Signature of coroner
8. Signature of registrar
9. Signature of witness
10. Signature of funeral director
11. Signature of undertaker
12. Signature of cemetery
13. Signature of burial place
14. Signature of interment place
15. Signature of final resting place
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Form Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
9884 MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY in 1b <u>14 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>408 OVERBROOK ROAD</u>					2. USUAL RESIDENCE (Where deceased lived, if institution, give name of institution) (If outside corporate limits, write RURAL and give nearest town) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN <u>TOWSON</u> d. STREET ADDRESS <u>408 OVERBROOK RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>C.</u> Last <u>BULLEN</u>					4. DATE OF DEATH Month <u>SEPT.</u> Day <u>12</u> Year <u>1961</u>									
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 12, 1909</u>		9. AGE (In years last birthday) <u>52</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GAST ELEC. CO</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						
13. FATHER'S NAME <u>JOHN COPPINGER</u>					14. MOTHER'S MAIDEN NAME <u>BROGAN</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>212-05542</u>					17. INFORMANT Address <u>Mr. Wm. J. BULLEN 408 OVERBROOK RD</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. DUE TO (c) } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sudden</u>										INTERVAL BETWEEN ONSET AND DEATH				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>Charles F O'Donnell</u> M.D.					CHIEF MEDICAL EXAMINER									
EXAMINER'S NAME (Type) <u>Charles F O'Donnell</u>					DEPUTY MEDICAL EXAMINER									
					DATE SIGNED <u>9/13/61</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					22b. DATE THEREOF <u>SEPT 15, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>					
23. FUNERAL DIRECTOR <u>HENRY W JENKINS & SONS</u>					ADDRESS <u>4905 YORK RD BALT 12, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>					

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9885 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										09876	
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				c. LENGTH OF STAY in 1b <u>49 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3536 GLENHURST Rd</u>						d. STREET ADDRESS <u>3536 GLENHURST Rd</u>					
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>BURAKIEWICZ</u> Last <u>BURAKIEWICZ</u>						4. DATE OF DEATH Month <u>9</u> Day <u>13</u> Year <u>1961</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-1-1895</u>		9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>13</u> Hours <u>19</u> Min. <u>61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ESSKAY CO</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>POLOAND</u>				11. BIRTHPLACE (State or foreign country) <u>USA</u>			
13. FATHER'S NAME <u>MICHAEL BURAKIEWICZ</u>						14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u>213-10-3508</u>		17. INFORMANT <u>HELEN BURAKIEWICZ GLENHURST</u>		Address <u>3536</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>9-14-61</u>											
ACTUAL SIGNATURE <u>Jack Collins</u>		EXAMINER'S NAME (Type) <u>JACK COLLINS</u>		DATE SIGNED <u>9-14-61</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-16-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY</u>		22d. LOCATION (City, town, or country) (State) <u>BALTIMORE MD</u>					
23. FUNERAL DIRECTOR <u>Walter Dabrowski</u> ADDRESS <u>1005 DUNDALK AV.</u>						24a. REC'D BY REGISTRAR <u>SEP 18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kura</u>			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9886

CERTIFICATE OF DEATH

Reg. Dist. No. 09877

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fellowship Forest c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 602 Valley Lane		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fellowship Forest d. STREET ADDRESS 602 Valley Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FREDERICK Middle A. Last BURGEMEISTER		4. DATE OF DEATH Month Sept. Day 4 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 18, 1879
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 81 Days 81 Hours 81 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurateur- Retired		10b. KIND OF BUSINESS OR INDUSTRY Germany	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. Burgemeister		14. MOTHER'S MAIDEN NAME Marie ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. Robert T. Mohre, 602 Valley Lane	
17. INFORMANT Address Robert T. Mohre, 602 Valley Lane			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 450.0 DUE TO Chronic congestive failure & Electrolyte imbalance DUE TO Generalized atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death: 450.0 years		INTERVAL BETWEEN ONSET AND DEATH 450.0 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 4, 19 61 to Sept 4, 19 61 that I last saw the deceased alive on Sept 4, 19 61 , and that death occurred at 9:28 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE William H. Kieby, Jr. M.D.		ADDRESS (Street, city or town, state) 7729 GREENVIEW TERRACE FOWSON 4, MD.	
PHYSICIAN'S NAME (Type) William H. Kieby, Jr.		DATE SIGNED SEP 8 '61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 7, 1961	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.		24a. REC'D BY REGISTRAR SEP 8 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9887

CERTIFICATE OF DEATH

Reg. Dist. No. 09878

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE 575 MONASTERY AVE., BALT. 29	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3V 01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PICKERSGILL		d. STREET ADDRESS SAME AS ABOVE	
3. NAME OF DECEASED (Type or print) MRS. FLORA First Middle Last		4. DATE OF DEATH Sept 14 19 61 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 18, 1885 9. AGE (In years lost birthday) 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME THOMAS GLANVILLE	
14. MOTHER'S MAIDEN NAME KATIE PARKS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 220-14-4401		17. INFORMANT Mrs. Weaver 615 Chestnut Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cerebral Vascular Disease DUE TO (c) Primum C-V-A.		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-13 , 19 61 , to 9-14 , 19 61 , that I lost saw the deceased alive on 9-13 , 19 61 , and that death occurred at 5:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. Cook M.D.		ADDRESS (Street, city or town, state) 4-E-33rd St Baltimore 18 Sept 14 1961	
PHYSICIAN'S NAME (Type)		DATE SEP 18 '61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-18-61	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Baltimore		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9888

Reg. Dist. No. 09879

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7615 Gum Road				d. STREET ADDRESS 7615 Gum Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First John Middle E. Last Cantwell, Sr.				4. DATE OF DEATH Month September Day 26 , Year 19 61				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 15, 1906		
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman			10b. KIND OF BUSINESS OR INDUSTRY Maritime Service		11. BIRTHPLACE (State or foreign country) A.A. County, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Cantwell				14. MOTHER'S MAIDEN NAME Adeline R. Foster				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 219-01-7623		17. INFORMANT Address Mrs. Agnes M. Cantwell, 7615 Gum Road, Zone 22				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							INTERVAL BETWEEN ONSET AND DEATH 	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE M B Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/26/61		
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-29-61		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore County		
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Zone 2				24a. REC'D BY REGISTRAR SEP 28 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9889

CERTIFICATE OF DEATH

Item 14 Film 6294 9/8/61 ink

09880

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 9 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First JEAN Middle (NMI) Last CAPPARELLA		d. STREET ADDRESS 1139 Hollins Street	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/1/87	
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofer		10b. KIND OF BUSINESS OR INDUSTRY Roofing Company	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dominick Capparella		14. MOTHER'S MAIDEN NAME Mary unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 218-10-4113	
17. INFORMANT Clint. Rec. VAH, Balto. 18, Md. Ft. Howard Division		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANTROLATERAL MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SEVERE CORONARY ARTERIOSCLEROSIS (c) THROMBOSIS RIGHT AURICLE		INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EMBOLUS, RIGHT, PULMONARY INFARCTION, RIGHT, ANTRONEPHROSCLEROSIS		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 8/23/1961 to 9/1/1961 , that (we) last saw the deceased alive on 9/1/1961 , and that death occurred at 9:10AM , from the causes and on the date stated above.			
22a. SIGNATURE ERNEST O. BROWN, M.D.		22b. DATE SIGNED 9/2/61	
22c. PHYSICIAN'S NAME (Type) ERNEST O. BROWN, M.D.		22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-5-61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight Inc.		25a. REC'D BY REGISTRAR SEP 6 '61	
25b. REGISTRAR'S SIGNATURE Christina S. Thomas		25c. ADDRESS 6009 Harford Road Baltimore 14, Maryland	

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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the medical examiner or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9890

09881

1. PLACE OF DEATH e. COUNTY Baltimore			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2800 Page Drive			d. STREET ADDRESS 2800 Page Drive		
3. NAME OF DECEASED (Type or print) BENJAMIN H. CARNES			4. DATE OF DEATH Month Day Year September 5, 19 61		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1915		9. AGE (In years last birthday) 45 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Armco Steel Co.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Benjamin H. Carnes		14. MOTHER'S MAIDEN NAME Louise Neumann			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes.		16. SOCIAL SECURITY NO. WW11		17. INFORMANT Mrs. Fräida Carnes 2800 Page Drive-22	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) Coronary Occlusion					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE M.B. Davis		M.D. M.B. Davis, M.D.		DATE SIGNED 9/7/61	
EXAMINER'S NAME (Type) M.B. Davis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 8, 1961	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or country) (State) Baltimore, Md.		
23. FUNERAL DIRECTOR Ullrich Funeral Home Dundalk, Md.		24a. REC'D BY REGISTRAR SEP 13 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

18-000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9891				CERTIFICATE OF DEATH				09882			
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 27				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 27			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1929 Victory Drive				d. STREET ADDRESS 1929 Victory Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ruth E. Carnes				4. DATE OF DEATH September 14 1961				5. SEX female			
6. COLOR OR RACE white				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH April 3, 1890			
9. AGE (In years last birthday) 70/71 yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital Attendant				11. BIRTHPLACE (County & State, or foreign country) Monroe County, New York			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Charles L. Fishbaugh				14. MOTHER'S MAIDEN NAME Estella M. Sage			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no				17. INFORMANT Ralph A. Fishbaugh, 1929 Victory Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic Reaction, cataplectic type				INTERVAL BETWEEN ONSET AND DEATH 10h				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 6, 1961, to Sept 14, 1961, that (I) (we) last saw the deceased alive on Sept 14, 1961, and that death occurred at 8:00 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Florian P. Nadolski				22b. DATE SIGNED Sept 14, 61				22c. PHYSICIAN'S NAME (Type) Florian P. Nadolski, M.D.			
22d. ADDRESS 2103 Hancock Ferry Rd, Balt 27, Md				23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 9-16-61			
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial				23d. LOCATION (City, town or county) (State) Glen Burnie, Md				24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street			
25a. REC'D BY REGISTRAR DATE SEP 18 '61				25b. REGISTRAR'S SIGNATURE J. Thos. S. Kraus				VR A15 (4) 15M 9/60			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9892

CERTIFICATE OF DEATH

Reg. Dist. No.

09883

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE Balto.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOUSE IN THE PINES		d. STREET ADDRESS 207 SOUTH WICKHAM ROAD	
3. NAME OF DECEASED (Type or print) URIAH F. CASSELL		4. DATE OF DEATH Month SEPT. Day 5 Year 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 25, 1893
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES HENRY CASSELL		14. MOTHER'S MAIDEN NAME ROSA GRACE ALEXANDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES. 5/3/18 TO 6/18/19		16. SOCIAL SECURITY NO. 218 05 3412	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete heart block, myocardial insufficiency 433.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic cardio-vascular disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 27, 19 59 , to Sept. 5, 19 61 , that I last saw the deceased alive on Sept. 5, 19 61 , and that death occurred at 8:00 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4116 Edmondson Avenue DATE SIGNED 9/6/61			
ACTUAL SIGNATURE George A. Knipp		M.D. 4116 Edmondson Avenue	
PHYSICIAN'S NAME (Type) George A. Knipp, M. D.		Baltimore 29, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/8/61	22c. NAME OF CEMETERY OR CREMATORY WESTERN CEMETERY	22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTIMORE 13, MARYLAND		24a. REC'D BY REGISTRAR DATE SEP 8 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanes			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1938

CERTIFICATE OF DEATH

1938

DEATH RECORDS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11 & 12 Film G297 10/6/61 iwk

9893

CERTIFICATE OF DEATH

Reg. Dist. No.

09884

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>423 Dumbarton Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth J. Cassidy</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1874</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Elmer E. Cassidy</u>		Address <u>423 Dumbarton Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocarditis</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>unknown</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 5, 1961</u> , to <u>Sept. 17th, 1961</u> , that I last saw the deceased alive on <u>Sept. 16th, 1961</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Geo. W. Murgatroyd</u> M.D.		<u>401 E. 25th. St. Balto. 18, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Geo. W. Murgatroyd</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 20, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul E. Chenoweth Jr.</u>		ADDRESS <u>3617 Chestnut Ave.</u>	
24a. REC'D BY REGISTRAR <u>Sept 22 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Harris</u>	

CERTIFICATE OF DEATH

1900

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES H. HARRIS		Male		45		Jan 1, 1855		Baltimore, Md.	
6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF DECEASED	
Clerk		Heart Disease		Home		10:30 AM		James H. Harris	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF MINISTER		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF DECEASED		15. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED		19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF DECEASED		23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED		25. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF DECEASED		28. SIGNATURE OF DECEASED		29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED		34. SIGNATURE OF DECEASED		35. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED		39. SIGNATURE OF DECEASED		40. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED		43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED		45. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF DECEASED		48. SIGNATURE OF DECEASED		49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF DECEASED		53. SIGNATURE OF DECEASED		54. SIGNATURE OF DECEASED		55. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF DECEASED		58. SIGNATURE OF DECEASED		59. SIGNATURE OF DECEASED		60. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF DECEASED		63. SIGNATURE OF DECEASED		64. SIGNATURE OF DECEASED		65. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED		69. SIGNATURE OF DECEASED		70. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF DECEASED		73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED		75. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF DECEASED		78. SIGNATURE OF DECEASED		79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF DECEASED		83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED		85. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF DECEASED		88. SIGNATURE OF DECEASED		89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED		93. SIGNATURE OF DECEASED		94. SIGNATURE OF DECEASED		95. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED		99. SIGNATURE OF DECEASED		100. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9894

09885

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b 19 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X AERO ACRES.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 42 LEFT WING DRIVE				d. STREET ADDRESS 142 LEFT WING DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HOMER Middle CANTRELL Last CANTRELL				4. DATE OF DEATH Month SEPT Day 14 Year 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 31, 1910	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRONICS		10b. KIND OF BUSINESS OR INDUSTRY MARTINS		11. BIRTHPLACE (State or foreign country) WATER TOWN TENNESSEE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JESSE CANTRELL				14. MOTHER'S MAIDEN NAME BESSIE VAN TREASE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 408-18-0371		17. INFORMANT Address MRS HOMER CANTRELL 42 LEFT WING DRIVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 MYOCARDIAL INSUFFICIENCY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) HEPATIC CIRRHOSIS ACUTE & CHRONIC (c) 1 yr						INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from OCTOBER 1958 to SEPT 1961 , that (I) (we) last saw the deceased alive on 9-13-1961 , and that death occurred at 6:00 AM , from the causes and on the date stated above.							
22a. SIGNATURE <i>John B. Littleton M.D.</i>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) 1515 MARTIN BLVD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT 18, 1961		23c. NAME OF CEMETERY OR CREMATORY HEARD HILL CEMETERY		23d. LOCATION (City, town, or county) (State) WATERTOWN, TENNESSEE	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Lassahn Funeral Home</i>				25a. REC'D BY REGISTRAR SEP 15 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hays</i>	

CERTIFICATE OF DEATH

1933

02482

NAME: [illegible] SEX: [illegible] AGE: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

SIGNATURE OF DECEASED: [illegible]

SIGNATURE OF WITNESSES: [illegible]

DATE OF SIGNATURE: [illegible]

PLACE OF SIGNATURE: [illegible]

NAME OF REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible]

PLACE OF REGISTRATION: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

DATE OF SIGNATURE: [illegible]

PLACE OF SIGNATURE: [illegible]

SIGNATURE OF WITNESSES: [illegible]

DATE OF SIGNATURE: [illegible]

PLACE OF SIGNATURE: [illegible]

1
FOR STATE HEALTH DEPT. (M)
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, Form Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9895 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 5mth15dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL			2. USUAL RESIDENCE (Where deceased lived, if institution: 09886 admission) a. STATE Maryland b. COUNTY Prince George ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro, Maryland d. STREET ADDRESS General Delivery e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Samuel Last Chaney			4. DATE OF DEATH Month September Day 20 Year 1961			
5. SEX male			6. COLOR OR RACE white			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH April 10, 1878			
9. AGE (In years, mo. birth, yrs.) 83			10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. farming			10b. KIND OF BUSINESS OR INDUSTRY EMM Employed			
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME unknown Louis Chaney			14. MOTHER'S MAIDEN NAME unknown Marir Stallings			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) unknown			16. SOCIAL SECURITY NO. 577-10-6452			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Sub-dural hemorrhages DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 8-14-61 Pt. found with bruises on right side of face and head; apparent bruise of the left eye and bruising on backs of hands; exact cause of findings			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:30 8-14-61			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> hospital			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) not known.			20f. (City or town) Catonsville 28, Md. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE George M. Kieffer			M.D.			
EXAMINER'S NAME (Type) George M. Kieffer, M. D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			DATE SIGNED 9-21-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 9/23/61			
22c. NAME OF CEMETERY OR CREMATORY Smithville Cemetery			22d. LOCATION (City, town, or country) (State) Smithville, Md.			
23. FUNERAL DIRECTOR Richie Bros. Upper Marlboro, MD			ADDRESS			
24a. REC'D BY REGISTRAR SEP 29 '61			DATE			
24b. REGISTRAR'S SIGNATURE Arthur S. Krawe						

2382



APRIL 10, 1978

RAK Employed

----- Louis Cheney -----
----- Merle Stallings -----

[Handwritten signature]

Smithville Cemetery Smithville, 0/23/81 buried

1 ~~23~~
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9896 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09887

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE Vo b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltz - rural		c. LENGTH OF STAY IN 1b 4 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Winchester 83x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 826 Loyola Drive			d. STREET ADDRESS 407 MOSBY ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) LEWIS WILLARD CHANTLER First Middle Last			4. DATE OF DEATH SEPT 16 1961 Month Day Year		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 June 1895		9. AGE (in years last birthday) 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Research Director		10b. KIND OF BUSINESS OR INDUSTRY hine & cement		11. BIRTHPLACE (State or foreign country) Pi Hsberg Pa	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ISREAL CHANTLER			14. MOTHER'S MAIDEN NAME Annie Staeb		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/O		16. SOCIAL SECURITY NO.		17. INFORMANT Laura Chantler - same (wife) Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH Unknown Under
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John C. Hyle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9-16-61	
EXAMINER'S NAME (Type) JOHN C. Hyle		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 9-18-61	22c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Jackson & Sons		ADDRESS Beltz 14, Md.		24a. REC'D BY REGISTRAR DATE SEP 19 '61	24b. REGISTRAR'S SIGNATURE William J. Jackson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW STATE
HEALTH TEST

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

US887

[Faint, mostly illegible text and markings on the form, including what appears to be a signature and various checkboxes.]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9897

09888

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, residence prior to admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>121 Glenmore Ave</u>				d. STREET ADDRESS <u>121 Glenmore Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lloyd W. Clark</u>				4. DATE OF DEATH Month Day Year <u>Sept. 12/61</u> 19 <u>61</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 1, 1905</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elec Engineer Westinghouse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Herbert Clark</u>				14. MOTHER'S MAIDEN NAME <u>Mary V. Burman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>219-20-5932</u>			
17. INFORMANT <u>Mrs. Jane Clark w/rl</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Liver and Omentum</u> 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of Esophagus</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-8-</u> <u>1960</u> , to <u>9-12-</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>9-11-</u> <u>1961</u> , and that death occurred at <u>11 A.</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Wm. K. Gallager</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-14-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. K. Gallager, M.D.</u>				22d. ADDRESS <u>6209 Frederick Ave, Baltimore 28, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)				
<u>Burial</u>	<u>9/15/61</u>	<u>Woodlawn</u>	<u>Balto. 7. md</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wittler & Co. 1 Edmondson Ave</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 15 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



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Attorney
General

[Faint, illegible handwriting visible through the paper]

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9889 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Daniels c. LENGTH OF STAY IN 1b 20 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 93 Lower Brick Row						2. USUAL RESIDENCE (Where deceased lived, if institution, give name of institution) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Daniels d. STREET ADDRESS 93 Lower Brick Row e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) WILMER FRANKLIN COLE						4. DATE OF DEATH Month Day Year Sept. 4, 1961 19					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1906		9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cotton Mill				10b. KIND OF BUSINESS OR INDUSTRY Cotton Mill				11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME John Cole						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 237-10-9565		17. INFORMANT Jack Cole, 18 Upper Brick Row, Daniels, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE C.E.O. S.M. KIEFFER				M.D. CHIEF MEDICAL EXAMINER S.E.H.				DATE SIGNED 10/10/61			
EXAMINER'S NAME (Type) C.E.O. S.M. KIEFFER M.D.				DEPUTY MEDICAL EXAMINER 10/10/61							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-7-61		22c. NAME OF CEMETERY OR CREMATORY Daniels				22d. LOCATION (City, town, or country) (State) Daniels, Md			
23. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md						24a. REC'D BY REGISTRAR DATE SEP 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Fraser			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

9899

9899

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural			c. LENGTH OF STAY IN 1b X		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarm, Maryland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural				d. STREET ADDRESS Glenarm, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sister Mary Elinor Middle Collins Last Collins				4. DATE OF DEATH Month 9 Day 21 Year 19 61			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec, 12, 1886	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 74		IF UNDER 24 HRS. Hours 74 Min. 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher	
10b. KIND OF BUSINESS OR INDUSTRY Religious.		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME William Collins				14. MOTHER'S MAIDEN NAME Catherine Byrne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Sister M. Henrica Villa Maria, Glenarm, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sub-arachnoid hemorrhage DUE TO (c) 3 da. 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 da.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 19 55 to September 19 61 that I last saw the deceased alive on September 19 61 and that death occurred at 4:30 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Towson 4, Md. DATE SIGNED							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				PHYSICIAN'S NAME (Type) Charles F. O'Donnell 7501 York Road Towson 4, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-25-61.		22c. NAME OF CEMETERY OR CREMATORY Villa Maria Cemetery		22d. LOCATION (City, town, or county) (State) Notch Cliff nr Towson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles A. Geler 901 S. Conkling St.				24a. REC'D BY REGISTRAR DATE SEP 25 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2290

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		45		M		W		1875		BALTIMORE		MD		USA		USA	
MARRIED		WIDOWED		SINGLE		DIVORCED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
MARRIED		WIDOWED		SINGLE		DIVORCED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
JAN 12 1920		BALTIMORE		MD		USA		USA		JAN 12 1920		BALTIMORE		MD		USA	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		JAN 12 1920		BALTIMORE		MD		USA	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
JAN 12 1920		BALTIMORE		MD		USA		USA		JAN 12 1920		BALTIMORE		MD		USA	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		JAN 12 1920		BALTIMORE		MD		USA	

RECEIVED

STATE DEPARTMENT OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9900

CERTIFICATE OF DEATH

Item 4 Film G297 10/2/61 mh

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deal, Maryland	
c. LENGTH OF STAY IN 1b 6yr9mth19dys		d. STREET ADDRESS none	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John		4. DATE OF DEATH Month September Day 23 Year 1961	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 28, 1908	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 53 Days 23 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) odd jobs		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Crandall		14. MOTHER'S MAIDEN NAME Susan Parks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Cardiovasc. Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Central Nervous System Syphilis (Meningoencephalitis)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Dec. 2, 1961 to Sept 23, 1961 , that (I) (we) last saw the deceased alive on Sept 23, 1961 , and that death occurred at 5:45 M. from the causes and on the date stated above.			
22a. SIGNATURE Jose R. Crizaga		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Jose R. Crizaga		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-26-61	
23c. NAME OF CEMETERY OR CREMATORY Shenbert		23d. LOCATION (City, town or county) (State) Dence, Md	
24. FUNERAL DIRECTOR'S SIGNATURE T A Shuchter + Son		25a. REC'D BY REGISTRAR SEP 27 '61	
25b. REGISTRAR'S SIGNATURE Galcarell, Md		25c. REGISTRAR'S SIGNATURE Arthur S. Hume	

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Central Vascular Accident

Paroxysmal atrioventricular conduction

Central nervous system (neurological)

9-25-61

Columbia W

9-25-61

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
9901				09892							
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 45 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Accomack c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Horntown P. O. d. STREET ADDRESS Star Route Sinnickson e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) BENJAMIN F. CROPPER				4. DATE OF DEATH September 24 1961							
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 10, 1895		9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman	
						11b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (County & State, or foreign country) Wattsville, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Cropper				14. MOTHER'S MAIDEN NAME Mary Cropper							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I				16. SOCIAL SECURITY NO. 214-18-4460				17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PROSTATE DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE										INTERVAL BETWEEN ONSET AND DEATH 1 YEAR +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
2Dc. TIME OF INJURY Hour a.m. _____ p.m. 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town)		(County)		(State)	
21. I certify that (X) (this hospital) attended the deceased from August 10 1961 to Sept. 24 1961 , that (X) (we) last saw the deceased alive on September 24 1961 , and that death occurred at 5:35 P. M, from the causes and on the date stated above.											
22a. SIGNATURE SEBASTIAN RUSSO, M.D.				22b. PHYSICIAN'S NAME (Type or print)				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/25/61	
22c. ADDRESS VAH, BALTO. 18 MD., FT. HOWARD DIVISION											
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 9-28-61		23c. NAME OF CEMETERY OR CREMATORY Wattsville, Cemetery		23d. LOCATION (City, town or county) Wattsville, Virginia		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton, New Church, Virginia				ADDRESS				25a. REC'D BY REGISTRAR SEP 28 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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TESTIMONY OF DEAR

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Witnesses: [illegible]

Testimony of [illegible]

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Testimony of [illegible]

Testimony of [illegible]

Testimony of [illegible]

ATTESTATION OF DEAR

Witnesses: [illegible]

Testimony of [illegible]

[Signature]

Testimony of [illegible]

Testimony of [illegible]

Testimony of [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9902

09893

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN 1b <u>11/10/58</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood State Training School</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> d. STREET ADDRESS <u>-653 W. Bel Air Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Walter B. Cummings</u>		4. DATE OF DEATH Month <u>9</u> Day <u>1</u> Year <u>1961</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>9/10/02</u>		9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Aberdeen, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur Cummings (deceased)</u>						14. MOTHER'S MAIDEN NAME <u>Lydia Hinkson Cummings (deceased)</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>---</u>						17. INFORMANT <u>Rosewood Records, Owings Mills, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Mongolism with severe mental deficiency</u>												INTERVAL BETWEEN ONSET AND DEATH <u>7 weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (H) (this hospital) attended the deceased from <u>11-10-1958</u> to <u>9-1-1961</u> , that (H) (we) last saw the deceased alive on <u>9-1-1961</u> , and that death occurred at <u>9:00</u> A.M. from the causes and on the date stated above.													
22a. SIGNATURE <u>Edward J. Mathews</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>9-1-61</u>					
22c. PHYSICIAN'S NAME (Type) <u>Edward J. Mathews, M.D.</u>						22d. ADDRESS <u>Rosewood State Training School, Owings Mills, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>9/3/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>RD. Aberdeen, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>						25a. REC'D BY REGISTRAR DATE <u>SEP 6 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kimes</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9903											
09894											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>2 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 6</u> d. STREET ADDRESS <u>6413 Belair Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>SAMUEL J. DE MARCO</u>						4. DATE OF DEATH Month <u>September</u> Day <u>29</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/29/92</u>		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Drugs</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>			
13. FATHER'S NAME <u>Disipino DeMarco</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Cammaraja</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>220-05-3555</u>				17. INFORMANT Address <u>Clinical Records, VAH, Baltimore 18, Maryland</u> <u>Fort Howard Division</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANTEROLATERAL MYOCARDIAL INFARCTION</u> DUE TO (b) <u>CORONARY ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>POLYP, COLON</u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> <u>UNKNOWN</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>CHRONIC NEPHROSCLEROSIS</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (u) (this hospital) attended the deceased from <u>Sept. 27, 1961</u> to <u>Sept. 29, 1961</u> , that (u) (we) last saw the deceased alive on <u>Sept. 29, 1961</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Sebastian Russo</u> M.D. <u>SEBASTIAN RUSSO, M. D.</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>9/29/61</u>		22d. ADDRESS <u>VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIVISION</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE Md.</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck & Sons, 5305 Harford Rd., Balto. 14</u>						25a. REC'D BY REGISTRAR <u>OCT 3 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>			

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **9895**

9904

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 4 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Res., 14 Waterview Rd. 22, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARTMAN FRAZIER DILLINGHAM, SR.		4. DATE OF DEATH Sept. 27, 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1910
9. AGE (In years last birthday) 51 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret., Policeman in Newport News, Va.	11. BIRTHPLACE (State or foreign country) Asheville, N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Tilden Dillingham	
14. MOTHER'S MAIDEN NAME Grace Tucker		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Army, Cavalry	
16. SOCIAL SECURITY NO. 246-09-8752		17. INFORMANT Mrs. Ruth Dillingham, 14 Waterview Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-30-1961	
22c. NAME OF CEMETERY OR CREMATORY Green Hill		22d. LOCATION (City, town, or county) (State) Asheville, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		ADDRESS 7922 Wise Ave. 22, Md.	
24a. REC'D BY REGISTRAR OCT 2 '61		24b. REGISTRAR'S SIGNATURE Charles S. House	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1900

County of Baltimore

City of Baltimore

Residence

Residence

Age

Dec. 22, 1900. In view of the fact that the deceased was found dead on the street, the cause of death is unknown.

Dec. 22, 1900. In view of the fact that the deceased was found dead on the street, the cause of death is unknown.

Dec. 22, 1900. In view of the fact that the deceased was found dead on the street, the cause of death is unknown.

Dec. 22, 1900. In view of the fact that the deceased was found dead on the street, the cause of death is unknown.

Dec. 22, 1900. In view of the fact that the deceased was found dead on the street, the cause of death is unknown.

Dec. 22, 1900. In view of the fact that the deceased was found dead on the street, the cause of death is unknown.

CAUSE OF DEATH
The cause of death is unknown. The deceased was found dead on the street. The body was found in a state of decomposition. The cause of death is unknown.

CAUSE OF DEATH
The cause of death is unknown. The deceased was found dead on the street. The body was found in a state of decomposition. The cause of death is unknown.

CAUSE OF DEATH
The cause of death is unknown. The deceased was found dead on the street. The body was found in a state of decomposition. The cause of death is unknown.

CAUSE OF DEATH
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CAUSE OF DEATH
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CAUSE OF DEATH
The cause of death is unknown. The deceased was found dead on the street. The body was found in a state of decomposition. The cause of death is unknown.

Dec. 22, 1900. In view of the fact that the deceased was found dead on the street, the cause of death is unknown.

Dec. 22, 1900. In view of the fact that the deceased was found dead on the street, the cause of death is unknown.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9905						09896					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)					
a. COUNTY Baltimore						a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)						b. COUNTY Baltimore					
c. LENGTH OF STAY IN 1b 10 years						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2519 Yorkway						d. STREET ADDRESS 2519 Yorkway					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last HENRY LEWIS DuCHATEAU						Month Day Year September 17th 19 61					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1884		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blower		10b. KIND OF BUSINESS OR INDUSTRY Glass		11. BIRTHPLACE (County & State, or foreign country) Jumet, Belgium		12. CITIZEN OF WHAT COUNTRY USA					
13. FATHER'S NAME Paul A. DuChateau						14. MOTHER'S MAIDEN NAME Aline Sciliffet					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no						16. SOCIAL SECURITY NO. 191-01-3564					
17. INFORMANT Armand DuChateau						Address 1924 Merritt Blvd. Baltimore 22, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 20012 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lymphosarcoma of the lymph node (c) Hypertension generalized atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 4-14-39						INTERVAL BETWEEN ONSET AND DEATH 11-7-60					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 16 to Sept 16 , 19 61 , that (I) (X) last saw the deceased alive on Sept 16 , 19 61 , and that death occurred at 2:45A from the causes and on the date stated above.											
22a. SIGNATURE Eugene F. Navy M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/17/61			
22c. PHYSICIAN'S NAME (Typed) Eugene F. Navy, M.D.						22d. ADDRESS 7001 Mornington Road, Dundalk 22, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/20/61		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial		23d. LOCATION (City, town or county) (State) Point Marion, Penna.					
24. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md.						ADDRESS SEP 21 '61		25a. REC'D BY REGISTRAR Arthur S. Kraus		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9906

09897

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN tb 2 Days		2. USUAL RESIDENCE (Where deceased lived, if institution; if not, give full residence) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1307 Edmondson Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM R. EATON		First		Middle		Last		4. DATE OF DEATH Month September		Day 27		Year 19 61			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 17, 1902		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 5		IF UNDER 24 HRS. Days 1		Hours 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning		11. BIRTHPLACE (County & State, or foreign country) Louisburg, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.									
13. FATHER'S NAME Edward Eaton		14. MOTHER'S MAIDEN NAME Rebecca Ridley													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 188-10-0031		17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland		Address FORT HOWARD DIVISION									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRO-THROMBOSIS (c) DUE TO		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Sept. 25, 1961, to Sept. 27, 1961, that (1) (we) last saw the deceased alive on Sept. 27, 1961, and that death occurred at P.M., from the causes and on the date stated above.		20g. (County) Sept. 25, 1961, to Sept. 27, 1961, that (1) (we) last saw the deceased alive on Sept. 27, 1961, and that death occurred at P.M., from the causes and on the date stated above.		20h. (State) Sept. 25, 1961, to Sept. 27, 1961, that (1) (we) last saw the deceased alive on Sept. 27, 1961, and that death occurred at P.M., from the causes and on the date stated above.					
21. I certify that (this hospital) attended the deceased from Sept. 25, 1961, to Sept. 27, 1961, that (1) (we) last saw the deceased alive on Sept. 27, 1961, and that death occurred at P.M., from the causes and on the date stated above.		22a. SIGNATURE Thomas F. Crahan		22b. DATE SIGNED 9/28/61		22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTO. 18, MARYLAND, FORT HOWARD DIV.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Oct. 2-1961		23c. NAME OF CEMETERY OR CREMATORY Hampton National Cemetery		23d. LOCATION (City, town or county) Hampton, Virginia		23e. REC'D BY REGISTRAR SEP 29 '61		23f. REGISTRAR'S SIGNATURE Clayton L. Hanna					
24. FUNERAL DIRECTOR'S SIGNATURE John M. Johnson		24b. ADDRESS 1700 Druid Hill Ave., Balto. Md.		24c. DATE SEP 29 '61		24d. REGISTRAR'S SIGNATURE Clayton L. Hanna									

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

9907

99898

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Todds Farm, Ft. Howard				c. LENGTH OF STAY IN 1b 31 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res. Box 162, Ave. B. Ross Rd.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Todds Farm, Ft. Howard 19, Md.			
f. STREET ADDRESS Box 162 Ave. B Ross Rd. 19				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALMA Middle EKHOLM Last EKHOLM				4. DATE OF DEATH Month Sept. Day 20, Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 17, 1880	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min. 80		11. BIRTHPLACE (State or foreign country) Finland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Finland			
13. FATHER'S NAME Lindholm				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Gunnar Ekholm Box 162 Todds Farm 19,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - generalized DUE TO (c) Chronic Arteritis				INTERVAL BETWEEN ONSET AND DEATH 3 days 20 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Arteritis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 , 19 61 , to 9:20 , 19 61 , that I last saw the deceased alive on 9:15 , 19 61 , and that death occurred at 2 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE ROGER G. WINOSOR				ADDRESS (Street, city or town, state) DATE SIGNED 520 28th Balt 19 Md 9:21			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-22-1961		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Eastern Ave. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA 7922 Wise Ave. 22, Md.				24a. REC'D BY REGISTRAR DATE SEP 25 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kneave	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

PLACE IN CASE		DATE OF DEATH	
1. NAME OF DECEASED		2. SEX	
3. AGE		4. RACE	
5. OCCUPATION		6. MARITAL STATUS	
7. PLACE OF BIRTH		8. DATE OF BIRTH	
9. PLACE OF DEATH		10. CAUSE OF DEATH	
11. MEDICAL HISTORY		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	
15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN	
17. SIGNATURE OF BURIAL OFFICIAL		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF CHURCH OFFICIAL		20. SIGNATURE OF CEMETERY	
21. SIGNATURE OF HEALTH OFFICIAL		22. SIGNATURE OF COUNTY CLERK	
23. SIGNATURE OF STATE DEPARTMENT OF HEALTH		24. SIGNATURE OF BALTIMORE CITY CLERK	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

death certificate, page 4 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be filed with the State Dept. of Health prior to burial, creation, or removal of the remains.

VR A15 (4)
15M 9/60

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9908

09899

1. PLACE OF BIRTH a. COUNTY <u>Catonsville</u> <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence prior to admission) e. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>Catonsville</u>		c. LENGTH OF STAY IN lb <u>Summit Nursing Home</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Summit Nursing Home</u>		d. STREET ADDRESS <u>922 Calwell Road</u>	
3. NAME OF DECEASED (Type or print) <u>Ida</u> <u>Emily</u> <u>Eline</u>		4. DATE OF DEATH Month <u>September</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 5, 1876</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. AGE (In years last birthday) <u>85</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Rheinhold W. Kaul</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Carr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-10-2936</u>	
17. INFORMANT <u>Mrs. Vera G. Wolfe</u>		Address <u>922 Calwell Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Generalized arteriosclerotic CV disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1961</u> to <u>Sept 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 1961</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Earl Pass</u>		22b. DATE SIGNED <u>9-5-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>I. EARL PASS</u>		22d. ADDRESS <u>4081 Wilches Car Rd, Baltimore</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-6-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Woodlawn, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Johnson</u>		25a. REC'D BY REGISTRAR <u>SEP 6 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Wm J. Johnson</u>		25c. REGISTRAR'S SIGNATURE <u>Wm J. Johnson</u>	

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may be relied on by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

99900

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hanover Road				d. STREET ADDRESS Hanover Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Georgia Middle Rebecca Last Eyler				4. DATE OF DEATH Month Sept Day 12 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 8, 1890	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 12 Hours 19 Min.		IF UNDER 24 HRS. Months 71 Days 12 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Bozman				14. MOTHER'S MAIDEN NAME Salley Nutter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Thomas R. Eyler Address Baltimore, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Colon 153.8 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) metastatic Carcinoma to Liver						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from Sept 8 19 61 , that (I) (we) last saw the deceased alive on Sept 8 19 61 , and that death occurred on Sept 12 19 61 at 12:45 AM from the causes and on the date stated above.							
22a. SIGNATURE W H Foard		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept 12 1961			
22c. PHYSICIAN'S NAME (Type) W. H. Foard M.D.		22d. ADDRESS Manchester, Md 9-12-61					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 15, 1961		23c. NAME OF CEMETERY OR CREMATORY Haugh's Cemetery		23d. LOCATION (City, town, or county) (State) Carroll Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons Reisterstown, Md.				25a. REC'D BY REGISTRAR DATE SEP 18 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
a. COUNTY Baltimore						a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 9					
c. LENGTH OF STAY IN TB 8 days						d. STREET ADDRESS 6212 Lincoln Avenue					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) EMILE M. FISHER						4. DATE OF DEATH September 23 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 21, 1894		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor				10b. KIND OF BUSINESS OR INDUSTRY Clothing Industry				11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harris Fisher						14. MOTHER'S MAIDEN NAME Esther					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-1						16. SOCIAL SECURITY NO. 217-07-1648					
17. INFORMANT Clinical Records, VA Hospital						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA						INTERVAL BETWEEN ONSET AND DEATH 2 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491X (b) ASPIRATION						Unknown					
(c) ACUTE REACTIVE DEPRESSION						Weeks					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
Status postoperative, CA of the colon.											
Operation: Resection of ca of colon, 7/3/61											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 15 1961 to Sept. 23 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 23 1961 , and that death occurred at 6:45 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Frederick S. Donaldson						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.						22d. ADDRESS VAH, Baltimore 18, Md. Fort Howard Division					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9-24-61			23c. NAME OF CEMETERY OR CREMATORY Kurlander Cemetery			23d. LOCATION (City, town or county) (State) Baltimore Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis, Inc.						25a. REC'D BY REGISTRAR SEP 26 '61					
25b. REGISTRAR'S SIGNATURE Charles S. Kline											

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9911

CERTIFICATE OF DEATH

Item 1/4 Film G297 10/2/61 mh

09902

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>1807 Taylor Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1807 Taylor Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>Fritz</u> Last <u>Fritz</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>20</u> Year <u>19 61</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 15, 1913</u> 47 yrs.	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Fritz</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>218-03-6655</u>		17. INFORMANT <u>Mrs Lillian Fritz</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Artery to the heart</u> <u>358.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Ischemic</u> (c) <u>Sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/27, 1960</u> to <u>9/20, 61</u> , that (I) (we) last saw the deceased alive on <u>9/19</u> , 19 <u>61</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Wm. F. Rehner</u> M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Wm. F. Rehner</u>				22d. ADDRESS <u>11 W. 29th St Baltimore</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>9/23/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 22 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9912

09903

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHATONSVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>12 PAXSON AVE</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHATONSVILLE</u> d. STREET ADDRESS <u>112 PAXSON AVE.</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>MARGARET A. GAITHER</u> First Middle Last				4. DATE OF DEATH <u>SEPT 7 1961</u> Month Day Year													
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/17/1881</u>		9. AGE (In years last birthday) <u>100</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>CHARLES BOBLIT</u>						14. MOTHER'S MAIDEN NAME <u>BARBER</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.						17. INFORMANT <u>Mrs Myrtle Ridgely</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Occlusion</u> 420.1 DUE TO (b) <u>Cardio Vascular Disease & Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____												INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>Sudden</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from <u>March 1959</u> to <u>9/7</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>9/5</u> , 19 <u>61</u> , and that death occurred <u>8:20</u> from the causes and on the date stated above.																	
22a. SIGNATURE <u>Edna W. Johnson</u> 22c. PHYSICIAN'S NAME (Type)						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.		22b. DATE SIGNED									
22d. ADDRESS <u>3432 Frederick Ave Baltimore 9/7/61</u>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>9/11/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S</u>				23d. LOCATION (City, town or county) <u>Howard Co. Md.</u> (State)							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Macraft & Son - 28</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>									
DATE <u>SEP 13 '61</u>																	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

VR A15 (4)
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General Robert E. Thompson
Colonel Thompson
Colonel Thompson

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General Thompson

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General Thompson

General Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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9913
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09904

1. PLACE OF DEATH a. COUNTY <u>Balto</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>648 Coleraine Rd</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> d. STREET ADDRESS <u>648 Coleraine Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fred S. Galtton</u> First Middle Last 4. DATE OF DEATH <u>9/8/61</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 17, 1891</u> 9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Pullman Ret.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Va.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Frederick Galtton</u> 14. MOTHER'S MAIDEN NAME <u>Reip</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WWI</u> 16. SOCIAL SECURITY NO. <u>000-1-100000</u> 17. INFORMANT <u>Mrs. Elizabeth R. Galtton</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, sigmoid colon</u> DUE TO (b) <u>153.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) <u>Leo J. Gaver</u> attended the deceased from <u>Dec. 1951</u> , 19 <u>61</u> , to <u>Sept. 61</u> , that (I) <u>Leo J. Gaver</u> last saw the deceased alive on <u>Sept. 2, 1961</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Leo J. Gaver, M.D.</u> 22b. DATE <u>Sept. 8, 1961</u> 22c. PHYSICIAN'S NAME (Type) <u>Leo J. Gaver, M.D.</u> 22d. ADDRESS <u>1 Mallow Hill Ave., Baltimore 29, Md</u> 22e. REC'D BY REGISTRAR <u>SEP 13 '61</u> 22f. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>9/11/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Balto. National</u> 23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Brown & Son</u> ADDRESS <u>28</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9914
CERTIFICATE OF DEATH
09905

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>Holly Hill Nursing Home</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>1216 Ramblewood Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holly Hill Nursing Home</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Minnie C. Gettman</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-18-1887</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u>4</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John Reckenberger</u>			
14. MOTHER'S MAIDEN NAME <u>Catherine ?</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>George J. J. Gettman Jr.</u>				17. INFORMANT <u>George J. J. Gettman Jr.</u> Address <u>7102 Wardman Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> DUE TO (b) <u>Recurrent Carcinoma pelvic floor 4 yrs.</u> DUE TO (c) <u>primary in recto sigmoid</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>154 X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 14</u> , 19 <u>61</u> to <u>Sept 21</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Sept 20</u> , 19 <u>61</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>S.G. Sullivan</u>				22b. DATE SIGNED <u>9-21-61</u>		22c. PHYSICIAN'S NAME (Type) <u>S.G. Sullivan</u>	
22d. ADDRESS <u>1129 St Paul St Baltimore Md</u>				22e. REC'D BY REGISTRAR <u>SEP 25 '61</u>			
22f. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			
23b. DATE THEREOF <u>9/23/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>			
23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9915

09906

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b Forest Haven Nursing Home d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn d. STREET ADDRESS 2000 Oak Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Rose M. Getzendanner				4. DATE OF DEATH Sept. 7/61 Month Sept. Day 7 Year 1961			
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 26, 1887 yrs. 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Gustaf Friede				14. MOTHER'S MAIDEN NAME Louise Neurshr			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Leroy T. Getzendanner, 2000 Oak Drive Address Baltimore 7, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE - PULMONARY EMBOLISM DUE TO (b) ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE - PULMONARY EMBOLISM DUE TO (c) ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE - PULMONARY EMBOLISM PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE - PULMONARY EMBOLISM INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/11/1961 to 9/7/1961 , that (I) (we) last saw the deceased alive on 9/7/1961 , and that death occurred at 5:30 PM from the causes and on the date stated above.							
22a. SIGNATURE John H. Shaw M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/9/61	
22c. PHYSICIAN'S NAME (Type) John H. Shaw M.D.				22d. ADDRESS 5800 EDMONDSON AVE. CATONSVILLE, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 11/61		23c. NAME OF CEMETERY OR CREMATORY Lorraine Pk.		23d. LOCATION (City, town or county) (State) Baltimore 7, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. ADDRESS 4101 Edmondson Ave				25a. REC'D BY REGISTRAR SEP 11 '61 DATE		25b. REGISTRAR'S SIGNATURE Anthony L. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09907

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Garrison c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Valley & Garrison Rds.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison d. STREET ADDRESS Garrison & Valley Rds. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eleanor Johnston Gibson		4. DATE OF DEATH SEPTEMBER 7 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1880
9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 8 Days 7	IF UNDER 24 HRS. Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Bartlett S. Johnston		14. MOTHER'S MAIDEN NAME Caroline Brooks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give number or dates of service)	
17. INFORMANT Mr. Jack S. Ewing		Address Garrison, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intestinal tumor (malignant?) DUE TO gail arterio - sclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 4 days 3 weeks 4 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 10, 1961 to Sept 8, 1961 , that (I) (we) last saw the deceased alive on Sept 7, 1961 and that death occurred at 12 AM , from the causes and on the date stated above.			
22a. SIGNATURE Palmer R. Williams 22c. PHYSICIAN'S NAME (Type) Dr. Palmer Williams		22b. DATE SIGNED Sept 9, 61 22d. ADDRESS Linson Rd., Garrison, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/9/61	23c. NAME OF CEMETERY OR CREMATORY Green Mount	23d. LOCATION (City, town or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place		25. REC'D BY REGISTRAR DATE SEP 11 '61 25b. REGISTRAR'S SIGNATURE Christina S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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4 years - 1944
3 years - 1945
2 years - 1946
1 year - 1947

10 8 1944

10 1 1945

John F. Williams

of Williams & Jones, Inc.

John F. Williams & Jones, Inc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9917						09908					
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>107 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> d. STREET ADDRESS <u>Main Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>CLIFFORD</u> <u>E.</u> <u>GODLEY</u> First Middle Last						4. DATE OF DEATH <u>September 8</u> <u>1961</u> Month Day Year					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 22, 1893</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Television-Radio</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Newark, N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clifford R. Godley</u>						14. MOTHER'S MAIDEN NAME <u>Caroline J. Van Houghton</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give year or dates of service) <u>WW-1</u>						16. SOCIAL SECURITY NO. <u>221-05-6913</u>					
17. INFORMANT <u>Clinical Records, VA Hospital</u> <u>Baltimore, Maryland - FORT HOWARD DIVISION</u>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYELOGENOUS LEUKEMIA</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 24</u> , <u>1961</u> to <u>Sept 8</u> , <u>1961</u> , that <u>W</u> (we) last saw the deceased alive on <u>Sept. 8</u> , <u>1961</u> , and that death occurred at <u>9:35</u> a.m. from the causes and on the date stated above.											
22a. SIGNATURE <u>John D. Talbert</u> M.D.						22b. DATE SIGNED <u>9-9-61</u>					
22c. PHYSICIAN'S NAME (Type) <u>John D. Talbert</u> M.D.						22d. ADDRESS <u>VAH Baltimore Md - Ft Howard Division</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 11/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WESLEY CHAPEL CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>ROCK HALL</u> <u>MARYLAND</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin Williams</u> ADDRESS <u>Chestertown Md</u>						25a. REC'D BY REGISTRAR DATE <u>SEP 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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John A. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9918						09909					
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, c. LENGTH OF STAY IN lb 3 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Training School						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY 3 VC 1-4 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City d. STREET ADDRESS 743 E. Preston Street a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Jonathan First Melvin Middle GORDON Last						4. DATE OF DEATH 9 Month 20 Day 19 Year 61					
5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH 8/18/52 9. AGE (In years last birthday) 9 yrs. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent 10b. KIND OF BUSINESS OR INDUSTRY none						11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Melvin Gordon						14. MOTHER'S MAIDEN NAME Hazel Carpenter					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. --- 17. INFORMANT Rosewood Records, Owings Mills, Md.						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial pressure 237 X DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) Tumor 3rd ventricle; etiology undetermined DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 yrs. 8 yrs.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 8/29 , 19 58 to 9/20 , 19 61 , that (I) (we) last saw the deceased alive on 9/20/ , 19 61 , and that death occurred at 3:15 p.m. , the causes and on the date stated above.											
22a. SIGNATURE Harry G. Butler 22c. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.						22b. DATE SIGNED 9/21/61 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS Rosewood State Training School					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9/23/61 23c. NAME OF CEMETERY OR CREMATORY Balt. Nat. Cem. 23d. LOCATION (City, town or county) (State) Balt., Md.											
24. FUNERAL DIRECTOR'S SIGNATURE Milton E. Elchman ADDRESS 1129 n. Caroline St. 25a. REC'D BY REGISTRAR SEP 22 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Knaus											

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Walter C. Jackson
A.C. Jackson
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9919				CERTIFICATE OF DEATH				09910			
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY —					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN lb 13 1/2 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MASONIC HOME						d. STREET ADDRESS 4509 ARABIA AVE					
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH GORSUCH						4. DATE OF DEATH Month Day Year SEPT 15 19 61					
5. SEX FE		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-13-1878		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME GEORGE W. AWALT						14. MOTHER'S MAIDEN NAME CAROLINE PFEIFFER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) NO				16. SOCIAL SECURITY NO. 214-26-4791		17. INFORMANT Address Frank L. Smith Jr, Cockeysville Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiac 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Vascular disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 13 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 6-21 , 19 48 , to 9-15 , 19 61 , that (I) (we) last saw the deceased alive on 9-15 , 19 61 , and that death occurred at 5:00 P.M. , from the causes and on the date stated above.											
22a. SIGNATURE Walter T. Kees						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/15/61			
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES						22d. ADDRESS COCKEYSVILLE, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-18-61		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore					
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Baltimore						ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 20 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Krasner	

VR A15 (4)
15M 9/60

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Baltimore

Baltimore

Baltimore

18th Ave

Cockeyville

Masonic Home

4047 Park Ave

Elizabeth

Sept 12

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Housewife

Maryland

George W. Howard

Cherokee, Pfeiffer

(1)

214-20-11

Cherokee, Pfeiffer

Cherokee, Pfeiffer

London Park, Baltimore

2-11-11

Bureau

W. Cook, Inc., 1215 St. Paul Street, Baltimore

Sept 20, 11

Chas. E. R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>22 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				d. STREET ADDRESS <u>300 S. Stricker Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>RAYMOND E. GREEN</u>						4. DATE OF DEATH <u>September 2 19 61</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 16, 1926</u>		9. AGE (In years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sheet Metal Factory</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Carroll, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Raymond Green</u>						14. MOTHER'S MAIDEN NAME <u>Grace Meyers</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWII</u>				16. SOCIAL SECURITY NO. <u>217-20-0607</u>		17. INFORMANT <u>Clinical Records, VAH, BALTIMORE, MD.</u> <u>Fort Howard Division</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LAENNEC'S CIRRHOSIS</u> <u>581.1</u> <u>ESOPHAGEAL VARICES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ESOPHAGEAL VARICES</u> DUE TO (c) <u>GASTRIC HEMORRHAGE DUE TO (B)</u>										INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>UNKNOWN</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>TERMINAL BRONCHOPNEUMONIA</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 11, 1961</u> , to <u>September 2, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>September 2, 1961</u> , and that death occurred <u>12:30 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Ernest O. Brown, M.D.</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>9/2/61</u>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>ERNEST O. BROWN, M.D.</u>						22d. ADDRESS <u>VAH, BALTIMORE, MD. - FT HOWARD DIVISION</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-6-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE 28, MARYLAND</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm-Cook Blight Funeral Home, 6009 Harford Rd. Baltimore, Md.</u>						25a. REC'D BY REGISTRAR <u>SEP 6 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. House</u>			

VR A15 (4)
15M 9/60



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RELATIVE RISK
1.000

9921 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09912

VS. A15ME
5M 7/59

3321 FEDERAL EXAMINER'S CERTIFICATE OF DEATH 03412

1. Name of Deceased

2. Sex

3. Race

4. Date of Birth

5. Place of Birth

6. Date of Death

7. Place of Death

8. Cause of Death

9. Manner of Death

10. Signature of Examiner

11. Signature of Physician

12. Signature of Coroner

13. Signature of Registrar

14. Signature of Clerk

15. Signature of Deputy Clerk

16. Signature of Assistant

17. Signature of Agent

18. Signature of Inspector

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

9922

09913

1. PLACE OF DEATH a. COUNTY Howard <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Howard <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethrope		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2011 Northeast Ave.		e. STREET ADDRESS 12011 Northeast Ave.	
3. NAME OF DECEASED (Type or print) First SARAH Middle HARDMAN Last		4. DATE OF DEATH Month SEPT. Day 28, Year 1961	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1950
9. AGE (In years last birthday) 11 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Alex Boyer		14. MOTHER'S MAIDEN NAME Mary Kent	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Ethel Malachi		Address 616 N. Payson St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral Insufficiency 3yrs 8Mo. 16 Days. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Heart Disease ? DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Virus Infection (Pneumonitis) 10 days.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 18th, 1958 , to Sept. 28th, 1961 , that I last saw the deceased alive on Sept. 28th, 1961 , and that death occurred at 4:10 A.M. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. F. Maloney, M.D.		ADDRESS (Street, city or town, state) 57 Winters Lane DATE SIGNED Sept. 28-61	
PHYSICIAN'S NAME (Type) C. F. Maloney, M.D.		Catonsville 28. Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 2, 1961	22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Kate R. Williams		ADDRESS 322 N. Schroeder St.	
24a. REC'D BY REGISTRAR OCT 2 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Krawe	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

Handwritten signature and date at the bottom of the page.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9923 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09914

1. PLACE OF DEATH a. COUNTY Sparks-Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence prior to admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Diecraft Factory- York Road		d. STREET ADDRESS 5900 Glenkirk Road	
3. NAME OF DECEASED (Type or print) Vernon M. Hart Sr.		4. DATE OF DEATH Month September Day 18 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Security Guard		10b. KIND OF BUSINESS OR INDUSTRY Pinkerton	9. AGE (In years last birthday) 53 yrs.
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William S. Hart		14. MOTHER'S MAIDEN NAME Mary Gibbons	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World War II		16. SOCIAL SECURITY NO. 215-03-4822	
17. INFORMANT Mrs. Lillian B. Hart Sr.		Address -5900 Glenkirk Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. O'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) 9/18/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-21-61	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or country) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR Wm J. Lockman & Sons		24a. REC'D BY REGISTRAR SEP 20 '61	
ADDRESS Baltimore 13 Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the spaces provided by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9924

09915

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN lb 3 days		d. STREET ADDRESS 233 Taylor Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1925 York Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma Matilda Hatswell		4. DATE OF DEATH Month Sept. Day 20 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1882
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months 7 Days 10 Hours 10 Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Walter Daniels		14. MOTHER'S MAIDEN NAME Emma M. Wells	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. 216-30-0241	
17. INFORMANT G. Robert Lyles Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Coronary Thrombosis IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-20-1961 , to 9-20-1961 , that (I) (we) last saw the deceased alive on 9/20/1961 , and that death occurred at 5:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE M. K. Quinn M.D.		22b. DATE SIGNED 9/20/61	
22c. PHYSICIAN'S NAME (Type) M. KEVIN QUINN		22d. ADDRESS 1927 YORK RD, TIMONIUM MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-23-61	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25a. REC'D BY REGISTRAR SEP 22 '61	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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June 15, 1982

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James R. Wells

Walter Tannish

218-20-0211 E. Robert Lyle Hagerstown, Md.

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M. X. Quinn
M. Kevin Quinn

1922 York Rd. Hagerstown, Md.

Hagerstown, Md.

Base Hill Cemetery

9-25-81

Funeral

Scott L. Minnich & Son Hagerstown, Md.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9925

09916

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 23 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2714 Gray Manor Terrace					
3. NAME OF DECEASED (Type or print) EDWARD A. HEISTERMAN				4. DATE OF DEATH September 21 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH February 7, 1898			
9. AGE (in years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George W. Heisterman				14. MOTHER'S MAIDEN NAME Linda Russell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) WW I				16. SOCIAL SECURITY NO. 215-07-9887					
17. ADDRESS Clinical Records, VAH, Baltimore 18, Maryland				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (e) RHEUMATIC HEART DISEASE (b) BILATERAL PULMONARY ATELECTASIS (c) BILATERAL HYDROTHORAX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 4 DAYS RECENT	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 29 1961 to September 21 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 21 1961 and that death occurred at 3:00 P.M. from the causes and on the date stated above.									
22a. SIGNATURE S. Russo M.D.				22b. DATE SIGNED 9/21/61		22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9-25-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 14				25a. REC'D BY REGISTRAR SEP 26 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9926

09917

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY —		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 52 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 14	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital			d. STREET ADDRESS 2619 Moore Avenue		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) GERALD P. HESS			4. DATE OF DEATH Month September Day 30 Year 19 61		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 10, 1918	9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months — Days —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bull Dozer Operator		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Saluvia, Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME George R. Hess		
14. MOTHER'S MAIDEN NAME Viole Sipe			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-11		
16. SOCIAL SECURITY NO. 204-03-2979			17. INFORMANT Clinical Records, VA Hospital Baltimore 18, Md - FORT HOWARD DIVISION		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA (b) UREMIA (c) ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 24 Hours 2 yrs. 2-3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 9, 1961 to Sept. 30, 1961 that (X) (we) last saw the deceased alive on Sept. 30, 1961 , and that death occurred at 1:45 P.M. from the causes and on the date stated above.					
22a. SIGNATURE WALTER J. PIJANOWSKI, M.D.		22b. ADDRESS VAH, Baltimore 18, Maryland Fort Howard Division		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/3/61		23c. NAME OF CEMETERY OR CREMATORY Siding Hill Chr. Church Cemetery	
23d. LOCATION (City, town or county) Harrisonville		(State) Penna.		25a. REC'D BY REGISTRAR OCT 3 '61	
24. FUNERAL DIRECTOR'S SIGNATURE Sander & Sons, Inc.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. ADDRESS North Ave. & Broadway Baltimore, Maryland	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
9927														
99918														
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 10 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22			d. STREET ADDRESS 304 Wheeler Court						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last BENJAMIN ---- HEYWARD					4. DATE OF DEATH Month Day Year September 10 19 61									
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 24, 1920 40		9. AGE (In years last birthday) Months Days Hours Min. 40 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Steel Company			11. BIRTHPLACE (County & State, or foreign country) Ridgeland, S. Carolina		12. CITIZEN OF WHAT COUNTRY U. S. A.						
13. FATHER'S NAME Julius Heyward					14. MOTHER'S MAIDEN NAME Sarah Robinson									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW II					16. SOCIAL SECURITY NO. 155-05-8561					17. INFORMANT Address Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER 581.0 XXXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMONIA, BILATERAL DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 3 DAYS +														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) August 31 19 61 to September 10 19 61 3:25 P.M. 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 31 19 61 to September 10 19 61 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 10 19 61 , and that death occurred on Sept. 10 19 61 , from the causes and on the date stated above.														
22a. SIGNATURE Sebastian Russo					22b. DATE 9/11/61									
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.					22d. ADDRESS VAH, BALTIMORE 18 MD, FT. HOWARD DIVISION									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9-12-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery			23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland						
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson, 1000 Brantley Ave., Balto. 17 Md.					25a. REC'D BY REGISTRAR SEP 15 '61					25b. REGISTRAR'S SIGNATURE Arthur L. Hines				

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9928

11098

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard 2 Days c. LENGTH OF STAY IN lb 2 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie 228-2 d. STREET ADDRESS 32 First Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) GEORGE E HILL		4. DATE OF DEATH Month September Day 30 Year 19 61		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14, 1893		9. AGE (In years last birthday) 68 yrs. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boat Builder		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland		11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Dave Hill				14. MOTHER'S MAIDEN NAME Emma Rossmarck				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-1				16. SOCIAL SECURITY NO. 218-01-2473				17. INFORMANT Clin Rec VAH Baltimore Md Ft Howard Division							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO CORONARY ARTERY THROMBOSIS (b) PULMONARY EDEMA DUE TO ARTERIOSCLEROTIC HEART DISEASE (c) GENERALIZED ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 16 HOURS 21 MONTHS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Sept. 28, 1961, to Sept. 30, 1961 9:30 A.M. 20g. (County) Baltimore 20h. (State) Maryland																							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 28, 1961, to Sept. 30, 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 30, 1961 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.																							
22a. SIGNATURE Charles E. Rowan M.D. 22b. DATE SIGNED 9-30-61 22c. PHYSICIAN'S NAME (Type) Charles E. Rowan M.D. 22d. ADDRESS VAH Baltimore Md - Ft Howard Division																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9-4-61				23c. NAME OF CEMETERY OR CREMATORY Baltimore National				23d. LOCATION (City, town or county) (State) Baltimore Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.																25a. REC'D BY REGISTRAR DAI 10 '61				25b. REGISTRAR'S SIGNATURE Charles E. Rowan			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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Washington

Washington

John Smith

John Smith

John Smith

22 First Avenue

Vegetarian Association, Inc.

March 10, 1933

Washington

John Smith

John Smith

John Smith

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March 10, 1933

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John Smith

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John Smith, Washington

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22-01-2-13 John Smith, Washington, D.C. - 12th Ward Division

John Smith

John Smith

John Smith, Washington

John Smith
22 First Avenue

John Smith, Washington
Vegetarian Association, Inc.

John Smith, Washington

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John Smith, Washington, D.C. - 12th Ward Division

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) o. STATE MARYLAND b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER		c. LENGTH OF STAY IN 1b X MIDDLE RIVER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1540 BORTON AVE		d. STREET ADDRESS 1540 BORTON AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First VENA Middle E Last HILL		4. DATE OF DEATH Month SEPT. Day 20 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1889
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) N. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HAMILTON		14. MOTHER'S MAIDEN NAME HUGHES ELIZ. ODOM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (I)		16. SOCIAL SECURITY NO.	
17. INFORMANT WM. HILL		Address 2512 IVERSON ST. WASH. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Cerebro-vascular accident DUE TO (b) Arterio-sclerotic cerebro-vascular disease DUE TO (c) lying cause lost. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day 10 yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1952 to Sept 20, 1961 , that (I) was last saw the deceased alive on Sept 20, 1961 , and that death occurred at 12 P. M. from the causes and on the date stated above.			
22a. SIGNATURE John S. Semenovoff		22b. DATE SIGNED 9/21/61	
22c. PHYSICIAN'S NAME (Type) LOUIS SEMENOVFF		22d. ADDRESS 2108 CRENSHAW RD, BALTO 20, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-22-61	
23c. NAME OF CEMETERY OR CREMATORY JEFFERSON CEMETERY		23d. LOCATION (City, town, or county) (State) JEFFERSON, PA.	
24. FUNERAL DIRECTOR'S SIGNATURE John S. Connolly		25a. RECEIVED BY REGISTRAR SEP 25 '61	
ADDRESS 4186 Eastern Blvd, Baltimore 21		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEP. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSMC
SM 9/60

MD
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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Item 9 Film C294 9/11/61 mb

99920

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY in 1b 10 years		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk (22)		d. STREET ADDRESS 3456 Dunran Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CLIFFORD CHARLES HISKER, Jr.		4. DATE OF DEATH September 1 19 61		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 7th, 1928		9. AGE (In years last birthday) 32 31 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Recorder		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Clifford C. Hisker, Sr.		14. MOTHER'S MAIDEN NAME Elizabeth Epperson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 46-47 218-22-3735					
17. INFORMANT Mary B. Hisker		18. ADDRESS same as #2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4200 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart Disease. (c) Arteriosclerotic Heart Disease. DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		21. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		21. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		21. DATE SIGNED 9/1/61		21. ACTUAL SIGNATURE Charles S. Petty		21. EXAMINER'S NAME (Type) Charles S. Petty		21. Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/61		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		22d. LOCATION (City, town, or country) (State) Baltimore Co., Maryland		23. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk 22, Md.		24a. REC'D BY REGISTRAR SEP 6 '61		24b. REGISTRAR'S SIGNATURE Charles S. Petty		24c. DATE					

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87015-15-1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, date of admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - FREEHAND. d. STREET ADDRESS S. RUHL RD.	
3. NAME OF DECEASED (Type or print) KATIE MAY HOFFMEISER		4. DATE OF DEATH Month 9 Day 3 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 9, 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 91 yrs.
11. BIRTHPLACE (State or foreign country) BALTO. CO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID WIRTZ		14. MOTHER'S MAIDEN NAME RUTH WALKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Charles Hoffmeister, Mayland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUNSHOT WOUND OF HEAD DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by UNKNOWN ASSAILANT	
20c. TIME OF INJURY Hour 10 — p.m. Month, Day, Year 9/3 1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) (County) (State) S. RUHL RD - BALTO. CO MD.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.S. Fisher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R.S. Fisher		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/4/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 7, 1961	
22c. NAME OF CEMETERY OR CREMATORY STILTZ CEMETERY		22d. LOCATION (City, town, or country) (State) RD #3 GLEN ROCK, PA.	
23. FUNERAL DIRECTOR J. Freed & Hartman, New Freedom, Pa.		24a. REC'D BY REGISTRAR SEP 11 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN lb MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 504 B Castle Drive		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Anneslee d. STREET ADDRESS 504 B. Castle Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah W Hoffman		4. DATE OF DEATH September 10 19 61	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 15, 1875	
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days 10 19 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
13. FATHER'S NAME William A. Crawston		14. MOTHER'S MAIDEN NAME Annabelle Amos	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. Informant	
17. ADDRESS Mrs. Mary Bozman-504 B. Castle Drive		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 155.1 DUE TO Protein Conditions, if any, which gave rise to immediate cause (b) Granuloid Abdominal Metastasis (a), stating the underlying cause last. (c) Carcinoma of Gall Bladder PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Sept. 1, 19 61 to Sept. 10, 19 61 , that (I) (we) last saw the deceased alive on Sept. 9, 19 61 , and that death occurred at 10:30 M., from the causes and on the date stated above. 22a. SIGNATURE Charles E. Carr, Jr., M.D. 22c. PHYSICIAN'S NAME (Type) Charles E. Carr, Jr., M.D. 22d. ADDRESS 6201 York Road, Balto. 12, Md. 22b. DATE SIGNED 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9-13-61 23c. NAME OF CEMETERY OR CREMATORY Govans Presbyterian 23d. LOCATION (City, town or county) (State) Baltimore, Maryland 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. J. Jackson & Sons, Inc. Balto 17, Md. 25a. REC'D BY REGISTRAR SEP 13 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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09923

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence prior to admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL CO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>			
c. LENGTH OF STAY IN 1b <u>5 MONTHS</u>				d. STREET ADDRESS <u>9 Ritchie Highway</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>SAMUEL</u> Last <u>HOOK</u>				4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 24 1915</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u>46</u> Days <u>46</u> Hours <u>46</u> Min.		IF UNDER 24 HRS. Months <u>46</u> Days <u>46</u> Hours <u>46</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT SEAMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WIPER-ENGINE ROOM</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>ROBERT HOOK</u>				14. MOTHER'S MAIDEN NAME <u>MYRTLE HOLMES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-05-2972</u>		17. INFORMANT Address <u>Hospital Records, Mt. Wilson State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY ARTERY THROMBOSIS</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY TUBERCULOSIS FAR ADVANCED - ACTIVE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>00 2 X</u>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>APR. 6</u> 1961 to <u>SEPT. 16</u> 1961, that (I) (we) last saw the deceased alive on <u>SEPT. 16</u> 1961, and that death occurred on <u>SEP. 16</u> 1961, from the causes and on the date stated above.							
22a. SIGNATURE <u>W. Newcomer</u>				22b. DATE SIGNED <u>SEPT 16 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D. Superintendent</u>	
22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>				22e. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>		22f. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/20/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN</u>		23d. LOCATION (City, town, or county) (State) <u>AA CO.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Paul E. Chumow</u>				25a. REC'D BY REGISTRAR <u>SEP 19 1961</u>		25b. REGISTRAR'S SIGNATURE <u>Gordon S. Hines</u>	

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JAN. 24 1912

ROBERT HOCK

514-25815

MARY L. HOLMES

GEORGE W. THOMPSON

24 hours

PULMONARY TUBERCULOSIS - ADVANCED - ACUTE

Sept 16

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Sept 16

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Sept 16 1912

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9934

09924

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY in 1b 26 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 3214 HAMILTON AVENUE d. STREET ADDRESS 3214 HAMILTON AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BERNARD A. HOUSE		4. DATE OF DEATH Month Day Year September 10 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 14, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FLORIST		10b. KIND OF BUSINESS OR INDUSTRY FLORIST SHOP	9. AGE (In years last birthday) 63 IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) ELMIRA, NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES HOUSE		14. MOTHER'S MAIDEN NAME FRANCES BARRIAR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW-1		16. SOCIAL SECURITY NO. 213-34-6272	
17. INFORMANT CLIN REC VAH BALTIMORE MD-FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER OF GINGIVA 144X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 15, 1961 to Sept. 10, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 10, 1961 , and that death occurred at 1:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Daniel R. Zoll M.D.		22b. DATE SIGNED 9-10-61	
22c. PHYSICIAN'S NAME (Type) DANIEL R. ZOLL		22d. ADDRESS VAH BALTIMORE MD - FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/13/61	23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY	23d. LOCATION (City, town or county) (State) BALTIMORE MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE John F Denry Funeral Home		25a. REC'D BY REGISTRAR SEP 13 '61	25b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RECORDS AND RECORDS — BALTIMORE 1, MARYLAND
9935 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>		c. LENGTH OF STAY IN 1b <u>4 MO 18 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELIZABETH</u> Last <u>HOVERMILL</u>		4. DATE OF DEATH Month <u>9</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-24-1896</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James W. MATTHEWS</u>		14. MOTHER'S MAIDEN NAME <u>MARY McDEVITT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE?</u>	
17. INFORMANT <u>Hospital Records, Mt. Wilson State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>FAR Adv. Pulmonary Tuberculosis</u> 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Empyema left.</u> (c) <u>Congestive cardiac failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardio Vascular disease.</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-28-1961</u> to <u>9-15-1961</u> , that (I) (we) last saw the deceased alive on <u>9-15-1961</u> , and that death occurred at <u>SAM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Wm. Newcomer</u>		22b. DATE SIGNED <u>9/15/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D. Superintendent</u>		22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/18/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Montgomery Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 19 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

1933

1933

MONTGOMERY

MARYLAND

SILVER SPRING

1000 11th

10603 2 DOWNSIDE DR

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ELIZABETH HOBBS

MARY

3-24-1916 62

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HOUSE WIFE

MARYLAND

U.S.B.

MARY MCDONALD

JAMES W. MATHIAS

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NO

FAR ADV - Pulmonary tuberculosis

Endemic left

Chronic cardiac failure

Atherosclerosis, Coronary atherosclerosis

10-12-31 1933-34

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9936

09926

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY in 1b 5yr11mth22dys	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Maole Ireland		4. DATE OF DEATH Month Sept. Day 23 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 9, 1882
9. AGE (In years last birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Thomas Ireland	
14. MOTHER'S MAIDEN NAME Fannie Howard Baseman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 134-10-9169		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Chron. Brain Syndr. assoc. with cerebral arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Chron. Brain Syndr. assoc. with cerebral arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 30, 1955 , to Sept. 23, 1961 , that (I) (we) last saw the deceased alive on Sept. 23, 1961 , and that death occurred 6 AM , from the causes and on the date stated above.			
22a. SIGNATURE Jose R. Arizaga, M.D.		22b. DATE SIGNED 9/23/61	
22c. PHYSICIAN'S NAME (Type) Jose R. Arizaga, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 25, 1961	23c. NAME OF CEMETERY OR CREMATORY Finksburg	23d. LOCATION (City, town or county) (State) Finksburg, Md.
24. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		25a. REC'D BY REGISTRAR SEP 25 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Krawe			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9937 CERTIFICATE OF DEATH 09927											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium c. LENGTH OF STAY IN 1b X d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 114 Oakway Rd. Timonium				2. USUAL RESIDENCE (Where deceased lived, If institutional, residence before admission) e. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X d. STREET ADDRESS Glenarm a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) VELMA L ISENNOCK				4. DATE OF DEATH Month Sept. Day 30 Year 19 61							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 11, 1907		9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 3 Days 05	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) File Clerk				10b. KIND OF BUSINESS OR INDUSTRY M Harford Co. Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Walter L Crowl				14. MOTHER'S MAIDEN NAME Hannah L. Iley							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. No				17. INFORMANT Mrs. Velma I Eyre Address 114 Oakway Rd. Tim.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) METASTATIC CARCINOMA 170X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) CARCINOMA OF LEFT BREAST DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)										INTERVAL BETWEEN ONSET AND DEATH 3 mos 1 YR	
21. I certify that (I) (this hospital) attended the deceased from 7/29 , 19 61 , to 9/30 , 19 61 , that (I) (we) last saw the deceased alive on 9/29 , 19 61 , and that death occurred at 8 A.M. from the causes and on the date stated above.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE William A. Pillsbury M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 9/30/61			
22c. PHYSICIAN'S NAME (Type) William A. Pillsbury, M.D.				22d. ADDRESS Timonium, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/3/61		23c. NAME OF CEMETERY OR CREMATORY Belair Mem. Gardens				23d. LOCATION (City, town or county) (State) Belair, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE William Cook-Towson, Inc.				ADDRESS 1050 York Rd.				25e. REC'D BY REGISTRAR DATE OCT 2 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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9938

CERTIFICATE OF DEATH

Reg. Dist. No. 99928

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella			c. LENGTH OF STAY IN 1b Oella		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 933 Oella Ave			d. STREET ADDRESS 933 Oella Ave.		
3. NAME OF DECEASED (Type or print) First Middle Last HAROLD LEON JACKSON			4. DATE OF DEATH Month Day Year Sept. 7, 1961. 19		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1890	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Woolen Mill	11. BIRTHPLACE (State or foreign country) Lewiston Maine		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Clarence L. Jackson			14. MOTHER'S MAIDEN NAME Florence H. Jackson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Clarence Jackson, 933 Oella Ave. Oella Md	INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia of Sebaceous Glands 179.7 "DUE TO" Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Seminal Vesicles 1 year (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Oella	(County) Calvert	(State) Md
21. I certify that I attended the deceased from March, 1961 to 9/7/61 , that I last saw the deceased alive on 8/25/61 , and that death occurred at 6:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) University Hospital DATE SIGNED 9/8/61 ACTUAL SIGNATURE Paris Phillips M.D. PHYSICIAN'S NAME (Type) PARIS PHILLIPS					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-11-61	22c. NAME OF CEMETERY OR CREMATORY Good Shepherd	22d. LOCATION (City, town, or county) (State) Ellicott City, Md		
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md			24b. REGISTRAR'S SIGNATURE Arthur S. Hines		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9939
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL MONKTON c. LENGTH OF STAY IN 1b 72 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution, residence, before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL MONKTON X d. STREET ADDRESS TROYER ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOANNA JACKSON First Middle Last		4. DATE OF DEATH SEPT. 1 1961 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH APRIL 22 1889 Month Day Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (RETIRED) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	11. BIRTHPLACE (County & State, or foreign country) BALTIMORE CO. MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JESSIE LEWIS	
14. MOTHER'S MAIDEN NAME FANNIE BERRY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. 315-32-1246		17. INFORMANT WILLIAM E. LEWIS Address TROYER ROAD MONKTON MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arterio sclerotic Cardiovascular Disease DUE TO (c) 10 yrs		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JAN 1959 to August 1961 , that (I) (we) last saw the deceased alive on Sept 1 1961 , and that death occurred at 1 A.M. from the causes and on the date stated above.			
22a. SIGNATURE C. Herbert Mueller Jr M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) C. HERBERT MUELLER JR		22d. ADDRESS PARKTON MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 9/4/1961	23c. NAME OF CEMETERY OR CREMATORY MT. JOY	23d. LOCATION (City, town or county) (State) MONKTON MD.
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kutz ADDRESS Jarrettsville Md.		25a. REC'D BY REGISTRAR SEP 5 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Hanna

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REPORT OF THE
COMMISSIONER OF THE
LAND OFFICE
OF THE STATE OF
NEW YORK
IN RESPONSE TO A
RESOLUTION OF THE
SENATE PASSED
MAY 10, 1893
RELATIVE TO THE
LANDS BELONGING
TO THE STATE
AND THE
MANNER OF
DISPOSING OF THEM

ALBANY:
J. B. LIPPINCOTT
PRINTERS
1893

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9940

CERTIFICATE OF DEATH

99930

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 169 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30 d. STREET ADDRESS 768 McHenry Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last PHILIP S. KELLY				4. DATE OF DEATH Month Day Year September 13 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Men's Clothing		9. AGE (In years last birthday) 72 yrs. IF UNDER 1 YEAR: Months Days Hours Min. January 1, 1889			
11. BIRTHPLACE (County & State, or foreign country) Neosho, Missouri				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Luke A. Kelly				14. MOTHER'S MAIDEN NAME Anna Rooney			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) Yes WW I				16. SOCIAL SECURITY NO. 212-16-0813			
17. INFORMANT Address Clinical Records, VA Hospital, Baltimore 18, Md. FORT HOWARD DIVISION				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, TERMINAL DUE TO (b) PULMONARY FIBROSIS AND EMPHYSEMA DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } INTERVAL BETWEEN ONSET AND DEATH FEW HOURS UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BENIGN PROSTATIC HYPERTROPHY - Duration Unknown							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		20g. (County) _____		20h. (State) _____			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 28 1961 to September 13/61 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 13 1961 , and that death occurred at 10:20 PM , from the causes and on the date stated above.							
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.				22b. DATE SIGNED 9/14/61 22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD MD. DIV.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-19-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.			
23d. LOCATION (City, town or county) Baltimore		23e. (State) 28, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.			
25a. REC'D BY REGISTRAR DATE SEP 18 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The original and four copies may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. The original and four copies may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. The original and four copies may be retained by the hospital or attending physician.

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Belmont

Port Howard

Veterans Administration Hospital

Y88 Henry's Street

PHILIP

B.

HELEN

September 13

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Male

White

January 1, 1939

Clark

Men's Clothing

Reeno, H. S. A.

Lake A. Kelly

Anna Rooney

Clinical records, VA Hospital, Port Howard, Division

NR 1

212-16-0013

PROBATION DEPARTMENT, TERMINAL

NEW HOUSE

PORT HOWARD HOSPITAL AND MATERNITY

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RECORDS DEPARTMENT - INMATE UNKNOWN

March 28

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September 13/61

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212-16-0013, Inc., 2000 National Ex., Belts, Va.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09931

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) House In The Pines Nursing Home				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gibson Island d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NATHANIEL SMITH KENNEY		4. DATE OF DEATH 8th September 1961		9. AGE (In years last birthday) 86 yrs. 8th September 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Supply (ret)		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (County & State, or foreign country) Virginia			
13. FATHER'S NAME (Unknown) Kenney		14. MOTHER'S MAIDEN NAME (Unknown) Cluak		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW 1		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mr. Richard C. Kenney Address Gibson Island, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure. 443X DUE TO (b) Chronic Hypertensive Cardio-Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 2 wks 15 yr.			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 5-14-1961, to 9-8-1961, that (I) (me) last saw the deceased alive on 9-8-1961, and that death occurred at 2P.M. from the causes and on the date stated above.							
22a. SIGNATURE Wilmer K. Gallagher M.D.				22b. DATE SIGNED 9/8/61			
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher				22d. ADDRESS 6609 Frederick Ave., Balt. 28, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11 Sept. 61		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery			
23d. LOCATION (City, town or county) Pikesville,		(State) Md.		25a. REC'D BY REGISTRAR SEP 13 '61			
24. FUNERAL DIRECTOR'S SIGNATURE R. V. Singleton		ADDRESS Glen Burnie, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Evans			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9942

09932

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN b. 2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS 423 49th Ave	
3. NAME OF DECEASED (Type or print) Robert W King		4. DATE OF DEATH Sep tember 16 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-17-88
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oiler		10b. KIND OF BUSINESS OR INDUSTRY TRANSIT Co	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME H enry King		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 578-10-6137	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia and azotemia DUE TO (b) Pyelonephritis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) 600.0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 3 weeks ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-21- to 9-16- 1961, that (I) (we) last saw the deceased alive on 9-16-61 19, and that death occurred at 12 noon from the causes and on the date stated above.			
22a. SIGNATURE H.I. Cholmondeley		22b. DATE SIGNED 9-16-61	
22c. PHYSICIAN'S NAME (Type) H.I. Cholmondeley		22d. ADDRESS Spring Grove State Hospital, Balt 28	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF 9/24/61	
23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN Cem		23d. LOCATION (City, town or county) (State) COLMAR MARSH MD	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS Co - 517-1195156		25. REC'D BY REGISTRAR SEP 19 '61	
ADDRESS WASHINGTON D.C.		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

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Reg. Dist. No. 4922

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cowings Mills</u>		c. LENGTH OF STAY IN 1b <u>59 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		d. STREET ADDRESS <u>506 W. Fayette St.</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Daniel</u> Last <u>Knapp</u>		4. DATE OF DEATH Month <u>September</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4 1891</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>+</u> Days <u>+</u>	IF UNDER 24 HRS. Hours <u>+</u> Min. <u>+</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>James Daniel Knapp</u>	
14. MOTHER'S MAIDEN NAME <u>Sophie L. Griffith</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Rosewood State Training School</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Cerebral Embolus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hematoma of scrotum</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>13 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 16</u> 19 <u>61</u> , to <u>Sept. 16</u> 19 <u>61</u> , that (I) met lost saw the deceased alive on <u>Sept. 16</u> 19 <u>61</u> , and that death occurred at <u>3:25</u> P. M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Grange A. Coffin</u>		22b. DATE SIGNED <u>Sept 16, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Grange A. Coffin, M.D.</u>		22d. ADDRESS <u>224 West Lorraine Street, Baltimore 17, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-20-61 Wm Anandson Burial</u>	23b. DATE THEREOF <u>9-20-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore, Md</u>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Purcell</u>		25. REC'D BY REGISTRAR <u>SEP 21 '61</u>	
ADDRESS <u>Pikes and</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. James</u>	

1900

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1

[Faint, illegible text and markings on a form, likely a death certificate, with two punch holes on the right side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9945
CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2905 Summit Avenue</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; if different, give address of admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u> d. STREET ADDRESS <u>2905 Summit Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <u>Mr. Robert Elmer Knickman</u>		4. DATE OF DEATH Month <u>September</u> Day <u>20</u> Year <u>1967</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 5, 1891</u>		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>watchman, N.B.C.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>Ann Herromanus</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give year or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u>218-18-1438 A</u>				17. INFORMANT Name <u>Mrs. Florence Knickman</u> Address <u>same</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abd. Generalized Carcinoma</u> <u>1538</u> DUE TO <u>Lower Bowel Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u> <u>6 mos.</u>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cachexia + edema</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>				20c. TIME OF INJURY Month, Day, Year Hour e.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1957</u> to <u>Sept 6/67</u> , that (I) (we) last saw the deceased alive on <u>Sept 1967</u> , and that death occurred at <u>9 AM</u> from the causes and on the date stated above.																							
22a. SIGNATURE <u>Frank T. Kasik Jr.</u>				22b. DATE SIGNED <u>9/24/67</u>				22c. PHYSICIAN'S NAME (Type) <u>Frank T. Kasik</u>				22d. ADDRESS <u>9005 Harford Road, Balto 14, Md.</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>9/23/67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Belaire Memorial Pk</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>							
25a. REC'D BY REGISTRAR <u>SEP 22 '67</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				25c. DATE <u>SEP 22 '67</u>				25d. SIGNATURE <u> </u>											

VR A15 (4)
15M 9/60

09932

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21-10-1901
James Brown
Catharine

21 10

James

James

Leonard J. 2305
James J. 2305
James J. 2305

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9946

CERTIFICATE OF DEATH

Reg. Dist. No.

09936

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before institution) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2106 Lukewood Drive				d. STREET ADDRESS 2106 Lukewood Drive			
3. NAME OF DECEASED (Type or print) First Middle Last PAULA S.C. KRON				4. DATE OF DEATH Month Day Year 9/21/61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/24/1903	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Bloomington, Ill.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Paul Brandhuber				14. MOTHER'S MAIDEN NAME Mary Zimmerman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. -			
17. INFORMANT Mr. Chris Kron				Address 2106 Lukewood Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Mar 19 59 to Sept. 21, 19 61 , that I last saw the deceased alive on Sept. 21, 19 61 , and that death occurred at 3:10 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6014 Edmonstone Dr. Sept 23, '61							
ACTUAL SIGNATURE Nelson McKay M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/61		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem		22d. LOCATION (City, town, or county) (State) Balto.	
23. FUNERAL DIRECTOR'S SIGNATURE WIEDEFELD & SON GREENMOUNT AVE & 22ND				24a. REC'D BY REGISTRAR DATE SEP 26 '61		24b. REGISTRAR'S SIGNATURE Carling S. Hunt	

CERTIFICATE OF DEATH

1904

1

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		Male		35		1869		Maryland	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH	
1100 E. 1st St.		Carpenter		Heart Disease		2 weeks		Home	
DATE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATIONS	
April 10, 1904		10:30 AM		101.0		110		24	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL DIRECTOR		SIGNATURE OF REGISTRAR	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
DATE OF REGISTRATION		TIME OF REGISTRATION		PLACE OF REGISTRATION		OFFICE OF REGISTRATION		OFFICE OF REGISTRATION	
April 10, 1904		10:30 AM		1100 E. 1st St.		Office of Health		Office of Health	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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9947

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. Maryland b. COUNTY B	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stoneloigh		c. LENGTH OF STAY IN 1b 2 Wks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armacest Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) BEATRICE LEANORE KRUSEN		4. DATE OF DEATH Sept. 19 , 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept, 9, 1900
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Philadelphia Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter L. Lewis		14. MOTHER'S MAIDEN NAME Lillian Strobel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John C. Krusen		Address 312 Melrose, Balto. 12	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1922 (b) MELANO-SARCOMA (RIGHT EYE) DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ADENO-CARCINOMA-SIGMOID COLON		INTERVAL BETWEEN ONSET AND DEATH 18 MONTHS 3 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from FEB 9, 1960 to SEPT. 19, 1961 , that (I) lost saw the deceased alive on SEPT. 19, 1961 , and that death occurred at 2:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Arthur Karfagin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ARTHUR KARFAGIN M.D.		22d. ADDRESS 1532 HAVENWOOD ROAD BALTIMORE 18	
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE THEREOF 9-22-61	
23c. NAME OF CEMETERY OR CREMATORY Lorraine		23d. LOCATION (City, town, or county) (State) Woodlawn Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		25a. REC'D BY REGISTRAR DATE SEP 21 '61	
ADDRESS Pikesville, md		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9948

CERTIFICATE OF DEATH

09938

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 76 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 24 Westchester Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Lilley Last Lafferty		4. DATE OF DEATH Month Sept. Day 21 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1885
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery store		10b. KIND OF BUSINESS OR INDUSTRY Retail	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Lafferty		14. MOTHER'S MAIDEN NAME Martha Lilley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-02-3768	
17. INFORMANT Mrs. Margaret McGuirk		Address 24 Westchester Ave. Catonsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 153.8 Metastatic Carcinoma, Colon DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 18 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Jan. 18, 1958 to Sept. 21, 1961 that (1) (we) last saw the deceased alive on Sept. 19, 1961 , and that death occurred at 10:35 AM , from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Herbert		22b. DATE SIGNED 9-22-61	
22c. PHYSICIAN'S NAME (Type) Thomas F. Herbert M. D.		22d. ADDRESS Church Road Ellicott City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/25/1961	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Easton Funeral Home		25a. REC'D BY REGISTRAR DATE SEP 25 '61	
ADDRESS Catonsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur E. Hines	

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9949 CERTIFICATE OF DEATH 09939											
1. PLACE OF DEATH a. COUNTY BALTIMORE COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River c. LENGTH OF STAY IN 1b 6 Months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holybeach avenue						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY 27 HOWARD COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKRIDGE * HARVARD PARK d. STREET ADDRESS 6904 ATHOL AVENUE 13X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CHARLES LAYMAN-KAZYS LAMANTAVICUS First also known as Last						4. DATE OF DEATH SEPT. 5 19 61 Month Day Year					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 4, 1886		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Keeper				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Lithuanian			12. CITIZEN OF WHAT COUNTRY Lithuania		
13. FATHER'S NAME Vincas Lamantavicus						14. MOTHER'S MAIDEN NAME Ursula Merkevicuite					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 220-05-9139-A		17. INFORMANT Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER 156.1 DUE TO UNDETERMINED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIO-VASCULAR-RENAL DISEASE DUE TO ARTERIOSCLEROSIS (c)								INTERVAL BETWEEN ONSET AND DEATH 3 1/2 YEARS 5 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (his/her) attended the deceased from 2 JUNE 37 5 SEPT 61 to 5 SEPT 61 , that (I) last saw the deceased alive on 3 SEPT 61 , and that death occurred AT HOME from the causes and on the date stated above.											
22a. SIGNATURE Edward F. Milan M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) EDWARD F. MILAN, M.D.						22d. ADDRESS 682 WASHINGTON BLVD, Z-30 BALTIMORE 30 MARYLAND		22b. DATE SIGNED 6 SEPTEMBER 61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 9/61		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer				23d. LOCATION (City, town or county) (State) Belair Rd. Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Charles W. Schuchman						ADDRESS 637 Wash Blvd		25a. REC'D BY REGISTRAR SEP 8 '61		25b. REGISTRAR'S SIGNATURE Charles W. Schuchman	

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Chronic of Liver
since 1910

Edward F. Kennedy
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9950

CERTIFICATE OF DEATH

Reg. Dist. No.

09940

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. LENGTH OF STAY IN 1b 30 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium Towson 4, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle LAWSON Last N		4. DATE OF DEATH Month 9 Day 25 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/84
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min.	11. IF UNDER 24 HRS. Months 7 Days 7 Hours 7 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Physician		10b. KIND OF BUSINESS OR INDUSTRY Bathhouse	
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Benjamin Lawson		14. MOTHER'S MAIDEN NAME Margaret Stockman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Personal History & Hospital Records, Eudowood Sanatorium		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer Liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 158.1 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis INTERVAL BETWEEN ONSET AND DEATH 3 mo			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/21 , 19 58 , to Sept 25 , 19 61 , that I last saw the deceased alive on Sept 27 , 19 61 , and that death occurred at 12:14 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Milton B. Kress, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Eudowood Sanatorium Md. 9/25/61	
PHYSICIAN'S NAME (Type) Eudowood Sanatorium, Towson 4, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-28-61	22c. NAME OF CEMETERY OR CREMATORY MORELANDS	22d. LOCATION (City, town, or county) (State) BALTO. MD.
23. FUNERAL DIRECTOR'S SIGNATURE John S. Connelly		24a. REC'D BY REGISTRAR SEP 28 '61	
ADDRESS 418 Eastern Blvd.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11138

Reg. Dist. No. 93912

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Parkton</u> c. LENGTH OF STAY IN 1b <u>Minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. 111 1 Mi. South of Parkton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Dauphin</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrisburg</u> <u>75X-3</u> d. STREET ADDRESS <u>2311 N. FRONT ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BENJAMIN L. LEVI</u> First Middle Last			4. DATE OF DEATH <u>SEPT. 24 1961</u> Month Day Year				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>July 13, 1906</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>		11. BIRTHPLACE (State or foreign country) <u>Harrisburg, Penna.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Jacob Levi</u>			
14. MOTHER'S MAIDEN NAME <u>Hanna Block</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>Unknown</u>			
16. SOCIAL SECURITY NO. <u>446 26 0991</u>		17. INFORMANT <u>911 N. Second St., Harrisburg, Pa.</u> <u>R. J. Reese</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed Chest</u> <u>819X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Time 10:15</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto mobile accident</u> <u>Station wagon crashed into bridge abutment</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>4</u> P. M. <u>9/24 1961</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 111</u> 20f. (City or town) <u>Barto.</u> (County) <u>Md.</u> (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>A. M. France</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>9/24/61</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 27, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beth El Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Paxtang, Penna.</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom, Pa.</u>			24a. REC'D BY REGISTRAR <u>DATE P 26 '61</u>				
24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

2951

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09943

09943

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN lb 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Spring Grove State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland Prigge Geo. b. COUNTY Lanham, Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1636-2 d. STREET ADDRESS 8805 Courtland Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BEATRICE - LEWIS First Middle Last		4. DATE OF DEATH 9 11 1961 Month Day Year	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH April 11, 1893		9. AGE (In years last birthday) yrs. 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Saunders		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown		17. INFORMANT RECORDS: Spring Grove State Hospital Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis - broncho-pneumonia, complicating 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Psychosis due to cerebral arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/11/61 Address (Street, city, town, or county)			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M. D.		22b. BURIAL, CREMATION, REMOVAL (Specify) Burial 22c. DATE THEREOF Sept 13 - 61 22d. NAME OF CEMETERY OR CREMATORY Fort Lincoln Md 22e. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR Francis Gaschi Sons Hyattsville Md ADDRESS		24a. REC'D BY REGISTRAR SEP 13 '61 DATE 24b. REGISTRAR'S SIGNATURE William S. Hanna	

VS. A15ME
5M 9/60

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [redacted] is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPT. OF THE ARMY
OFFICE OF THE CHIEF OF MEDICAL SERVICE



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

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MAYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWINGS MILLS c. LENGTH OF STAY IN 1b 60 YEARS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PAINTER'S MILL ROAD		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWINGS MILLS d. STREET ADDRESS PAINTERS MILL ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CARRIE BOULLEMET LIMERICK		4. DATE OF DEATH 9 4 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 17, 1878
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEVER EMPLOYED		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) NEW ORLEANS, LOUISIANA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROLAND H. BOULLEMET		14. MOTHER'S MAIDEN NAME CAROLINE BUCKLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mrs I.C. LYCETT	
17. INFORMANT ABOVE		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) Cerebral Thrombosis 4-20.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic & hypertensive (c) arterio-sclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 3 months 10 years 2 years?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 29 , 19 61 to Sept 4 , 19 61 , that (I) (we) last saw the deceased alive on Sept 4 , 19 61 , and that death occurred at 12 PM , from the causes and on the date stated above.			
22a. SIGNATURE F. C. Williams 22c. PHYSICIAN'S NAME (Type) F. C. Williams		22b. DATE SIGNED Sept 5 '61 22d. ADDRESS Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Sept 6, 1961	
23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMETERY		23d. LOCATION (City, town or county) (State) BALTIMORE COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE HENRY W. JENKINS & SONS ADDRESS 4905 YORK ROAD BALT 12		25a. REC'D BY REGISTRAR SEP 7 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9953 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09945

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, residence prior to admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex (21)				c. LENGTH OF STAY IN 1b Dundalk (22)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 419 Eastern Avenue				d. STREET ADDRESS 2983 Cornwall Road			
3. NAME OF DECEASED (Type or print) WALTER +++ LUEDECKE, Sr.				4. DATE OF DEATH Month September Day 22 Year 19 61			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 14, 1894	
9. AGE (in years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Luedecke				14. MOTHER'S MAIDEN NAME Anna (Unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. Elizabeth K. Luedecke same as #2			
17. INFORMANT Elizabeth K. Luedecke				Address same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A-S-C-V-DISEASE DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M B Davis				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/25/61			
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery				22d. LOCATION (City, town, or country) (State) Baltimore Co., Maryland			
23. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk 22, Md.				24a. REC'D BY REGISTRAR SEP 25 '61			
24b. REGISTRAR'S SIGNATURE Arthur S. Hines							

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1757 Brookview Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 1757 Brookview Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT W. LUPTON		4. DATE OF DEATH Month September Day 17 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1917
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months 43 Days 43 Hours 43 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10b. KIND OF BUSINESS OR INDUSTRY Balto. Co. Md.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert J. Lupton		14. MOTHER'S MAIDEN NAME Lottie Romoser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes, Marine Corps		16. SOCIAL SECURITY NO. 218-01-6199	
17. INFORMANT Mrs. Catherine Lupton		Address 1757 Brookview	
18. CAUSE OF DEATH (Give one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Contact Gunshot Wound of Head. 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) 976X (c) 976X DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head.	
20c. TIME OF INJURY Month, Day, Year 9/17 19 61 Hour a.m. xx		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Dundalk (County) Baltimore (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-20-1961	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or country) (State) Frederick Rd. Md.	
23. FUNERAL DIRECTOR JOHN J. DUDA		ADDRESS 7922 Wise Ave. 22, Md.	
24a. REC'D BY REGISTRAR SEP 21 '61		24b. REGISTRAR'S SIGNATURE Charles S. Petty	

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1727 Brooklyn St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Balto. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>—</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>2 mo.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Summit Nursing Home</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Joseph J. Machovec</i>		4. DATE OF DEATH Month Day Year <i>Sept. 27, 1961</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAY 8, 1887</i>
9. AGE (In years last birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RESTAURANTEUR</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>RETIRED</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>FRANK Machovec</i>		14. MOTHER'S MAIDEN NAME <i>FRANCES ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-32-8960</i>	
17. INFORMANT <i>MRS. AGNES MACHOVEC</i>		Address <i>1931 GRINNALLS.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic cardiovascular disease</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>August 1961</i> to <i>Sept 27, 1961</i> , that (I) (we) last saw the deceased alive on <i>Sept 26, 1961</i> , and that death occurred at <i>11 A.M.</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Justinas Kudirka</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>Justinas KUDIRKA</i>			
22d. ADDRESS <i>1709 Edmonson Ave, Catonsville</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			
23b. DATE THEREOF <i>9/30/61</i>			
23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem. Park Cem.</i>			
23d. LOCATION (City, town, or county) (State) <i>Washington Blvd. Balto. Md.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>George L. Schuman, Jr.</i> ADDRESS <i>2101 Frederick Ave</i>			
25a. REC'D BY REGISTRAR <i>OCT 2 '61</i>			
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krave</i>			

(M)

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9955

CERTIFICATE OF DEATH

09948

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Middle River</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oak Grove Apts.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>OAK GROVE APTS. - 3 Oak Grove Drive</u>				d. STREET ADDRESS <u>3 Oak Grove Drive</u>			
3. NAME OF DECEASED (Type or print) <u>ELIZABETH MARSH</u>				4. DATE OF DEATH Month <u>September</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 6, 1867</u>	
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Great Burin, Newfoundland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Stephen Moulton</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT (son) <u>Mr. Edgar L. Marsh, 3 Oak Grove Drive, Balto. Co.</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro - vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arterio-sclerotic cerebro-vascular disease</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Sept 6</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Sept 6</u> , 19 <u>61</u> , and that death occurred at <u>1 A.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Louis Semenovoff</u>				22b. DATE SIGNED <u>9/6/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOFF</u>				22d. ADDRESS <u>2108 OREMS RD BALTO 20, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 9, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Roslyn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Roslyn, L. I., N. Y.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>STEWART & MOWEN CO., 108 W. North Av., Balto. 1</u>				25a. REC'D BY REGISTRAR <u>SEP 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9958

CERTIFICATE OF DEATH

09950

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution, send her to an admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 115 Shetland Hills Drive				d. STREET ADDRESS 803 Wellington Road			
3. NAME OF DECEASED (Type or print) Mary McDaniel				4. DATE OF DEATH Month Sept. Day 14 Year 19 61			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-1886	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Emil Dorman				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-03-7993D		17. INFORMANT Mrs. w. J. Steele 115 Shetland Hills Dr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) CAUSE THE FAILURE (c) MYOTOMYCLEROTIC HEART DISEASE						INTERVAL BETWEEN ONSET AND DEATH 4725	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 5/11 to 9/14 , 19 61 , that (I) (we) last saw the deceased alive on 9/14 , 19 61 , and that death occurred at 10:15 PM on the causes and on the date stated above.							
22a. SIGNATURE Stuart G. Dwyer				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type or print) Stuart G. Dwyer	
22d. ADDRESS 201 E. 33rd ST.				22e. M.D.		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-18-61	23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City, town or county) Parkville		(State) Md.	
24 FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. 4905 York Rd. Balto				25a. REC'D BY REGISTRAR SEP 18 '61		25b. REGISTRAR'S SIGNATURE Walter S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 3 mo. 17 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4018 Gelston Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Timothy Middle McLaughlin Last McLaughlin		4. DATE OF DEATH Month 9 Day 26 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/26/05
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 3 Days 26 Hours 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James M. McLaughlin		14. MOTHER'S MAIDEN NAME Mary A. Ford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-10-5718	
17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Mouth 144X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Far Advanced Pulmonary Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH 13 mo.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 002X	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/9 19 61 to 9/26 19 61 that (I) (we) last saw the deceased alive on 9/26 19 61 , and that death occurred at 2A M, from the causes and on the date stated above.			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED 9/26/61	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/29/61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City, town, or county) (State) Balto Md	
24. FUNERAL DIRECTOR'S SIGNATURE Thomas J. Kenny Inc - Balto Md		25a. REC'D BY REGISTRAR SEP 29 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraw			

STATE OF TEXAS
COUNTY OF DALLAS

1900

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9960

09952

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 14 Ridge Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Isabel Meehan		4. DATE OF DEATH Month Day Year September 16 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19--1883
9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.		10a. USUAL OCCUPATION (during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Hannan		14. MOTHER'S MAIDEN NAME Mary Ann Clarke	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. Mrs Elizabeth Sima, 14 Ridge Rd; Catonsville, Md.	
17. INFORMANT Mrs Elizabeth Sima, 14 Ridge Rd; Catonsville, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory failure (b) Dehydrated & malnourished (c) Septicemia, chronic cholecystitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombocytopenic purpura INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1961, to 16 Sept 1961, that (I) (we) last saw the deceased alive on 16 Sept 1961, and that death occurred at 6:12 PM, from the causes and on the date stated above.			
22a. SIGNATURE William J. Bryson M.D.		22b. DATE SIGNED 18 Sept 61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-19-1961	23c. NAME OF CEMETERY OR CREMATORY Good Shepherd	23d. LOCATION (City, town or county) (State) Howard County-Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Edw. S. Mac Nabb Jr.		25a. REC'D BY REGISTRAR DATE SEP 20 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. ADDRESS Catonsville, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9961

09953

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 7yr8mth10 dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham, Maryland d. STREET ADDRESS Sheriff Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carrie Middle Megill Last Megill		4. DATE OF DEATH Month September Day 12 Year 1961		5. SEX female			
6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 27, 1879			
9. AGE (In years last birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11. BIRTHPLACE (County & State, or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) 422.1 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Jan. 2, 1961 to Sept. 12, 1961 , that (I) (we) last saw the deceased alive on Sept. 12, 1961 , and that death occurred at p.m. from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachslar M.D. 22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL (CREMATION, REMOVAL) (Specify) 9-14-61		23b. DATE THEREOF 9-14-61		23c. NAME OF CEMETERY OR CREMATORY Lee's Cemetery			
23d. LOCATION (City, town or county) (State) Washington D.C.		24. FUNERAL DIRECTOR'S SIGNATURE Free Funeral Home Wash. D.C.		25a. REC'D BY REGISTRAR SEP 18 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Knepp		25c. DATE SIGNED 9-13-61					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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The Journal Home 1111
9-14-61
Washington DC

CERTIFICATE OF DEATH

Reg. Dist. No.

9962

09954

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Resident or long-term patient) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 24</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 24</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2007 FAITH AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elmer David Melton Sr</u>				4. DATE OF DEATH Month Day Year <u>Sept 29 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 16, 1901</u>	
9. AGE (In years lost birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
13. FATHER'S NAME <u>Colombus David</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Lee Mooney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Navy</u> [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. <u>213-079194</u>			
17. INFORMANT <u>MRS ETTA MELTON</u>				Address <u>7007 FAITH AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept 29, 1960</u> , to <u>Sept 29, 1961</u> , that I last saw the deceased alive on <u>Sept 29, 1961</u> , and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leonard Berger</u>				DATE SIGNED <u>9/29/61</u>			
PHYSICIAN'S NAME (Type) <u>ULLRICH FUNERAL HOME - 4210 BELMONT</u>				M.D. <u>410 S. KATHLEEN AVE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/2/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>		22d. LOCATION (City, town, or county) (State) <u>OVERLEA MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME - 4210 BELMONT</u>				ADDRESS <u>4210 BELMONT</u>		24a. REC'D BY REGISTRAR <u>OCT 5 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>							

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. D 09955

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Parkton</i>		c. LENGTH OF STAY IN 1b <i>50yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Miller Lane</i>		d. STREET ADDRESS <i>Miller Lane</i>	
3. NAME OF DECEASED (Type or print) First <i>Hester</i> Middle <i>I.</i> Last <i>Miller</i>		4. DATE OF DEATH Month <i>September</i> Day <i>4</i> Year <i>1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 17, 1887</i>
9. AGE (In years last birthday) <i>73</i> yrs.		10. IF UNDER 1 YEAR: Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Freeland, Md</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Absolom Baker</i>		14. MOTHER'S MAIDEN NAME <i>Frances Turnbaugh</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary sclerosis</i> DUE TO (c) <i>3 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertensive Congestive Heart disease</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5-14-</i> , 19 <i>56</i> to <i>9-4-</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>8-30-</i> , 19 <i>61</i> , and that death occurred at <i>3:30 P.</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Paul D. Shaub</i>		ADDRESS (Street, city or town, state) <i>Shrewsbury, Pa.</i>	
PHYSICIAN'S NAME (Type) <i>Paul D. Shaub</i>		DATE SIGNED <i>9-5-61</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept 7, 1961</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Wiseburg Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>White Hall, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jacob Gartenstein</i>		ADDRESS <i>New Freedom, Pa.</i>	
24a. REC'D BY REGISTRAR <i>SEP 11 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Richard L. Hines</i>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

1900

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9964 CERTIFICATE OF DEATH 09956

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, 4		c. LENGTH OF STAY IN 1b 9 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8170 Glen Gary Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mrs. Catharine A. Monaghan		4. DATE OF DEATH Month Sept. Day 21 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1884
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Balto. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Malachy Lyons		14. MOTHER'S MAIDEN NAME Margaret Wynn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Marie B. Monaghan, Baltimore 4, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive pneumonia DUE TO 260 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerosis (Generalized) DUE TO Diabetes (c) Diabetes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 Hypertension		INTERVAL BETWEEN ONSET AND DEATH 48 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct-10, 1956 to Sept-21, 1961 , that (I) (we) last saw the deceased alive on 9-21-1961 , and that death occurred at 8 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Lee K Fargo		22b. DATE SIGNED 9-21-61	
22c. PHYSICIAN'S NAME (Type) LEE K FARGO M.D.		22d. ADDRESS 8151 LOCH RAVEN BLVD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-25-61	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Long Byers		25a. REC'D BY REGISTRAR DATE SEP 25 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9965

09957

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 1 Day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; otherwise, last residence) a. STATE Maryland b. COUNTY Baltimore 23 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 118 N. Carlton Street d. STREET ADDRESS 118 N. Carlton Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE ----- MULDROW			4. DATE OF DEATH Month Day Year September 9 19 61		
5. SEX Male			6. COLOR OR RACE Negro		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH July 7, 1893		
9. AGE (In years last birthday) 68 yrs.			10. IF UNDER 1 YEAR Months Days 68		
11. IF UNDER 24 HRS. Hours Min. 68			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Construction		
11. BIRTHPLACE (County & State, or foreign country) Darlington S. Carolina			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Ervin Muldrow			14. MOTHER'S MAIDEN NAME Jane Barry		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I			16. SOCIAL SECURITY NO. 220-05-7265		
17. INFORMANT Clinical Records V.A.H. FORT HOWARD DIVISION Baltimore 18, Maryland			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (b) XXXXXX (a), stating the underlying cause last. (c) HYPERTENSIVE CARDIOVASCULAR DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNKNOWN UNKNOWN UNKNOWN		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20. INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
21. I certify that (this hospital) attended the deceased from September 8 1961 to September 9 1961 , that (we) last saw the deceased alive on Sept. 9 1961 , and that death occurred at 11:20 P.M. from the causes and on the date stated above.			22. SIGNATURE Thomas F. Crahan M.D. 22b. DATE SIGNED 9/11/61		
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.			22d. ADDRESS VAH, BALTO. 18, MD., FT. HOWARD DIVISION		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9-12-61		
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery			23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson			25a. REC'D BY REGISTRAR SEP 15 '61		
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			25c. ADDRESS 1000 Brantley Ave.		

14

1962

1962

Baltimore

Maryland

Fort Howard

1 Hwy

Baltimore 23

Veterans Administration Hospital

1111 E. Carroll Street

Office

Office

September 9

Phone

July 1, 1962

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Constellation

Baltimore 2, Caroline

U. S. A.

John M. Morrow

John M. Morrow

Clinical Records, Fort Howard Division
Baltimore, Maryland

240-05-1962

WA 1

Yes

CENTRAL TENDRITIS
ANTHROPOLOGICAL

UNKNOWN
UNKNOWN

Office

RESEARCH DIVISION CARDIOVASCULAR DISEASE

UNKNOWN

September 9 11:30
September 9 11:30

61

Sept. 9

THOMAS J. GIBSON, M.D.

VAN, HALL, 16, 17, FORT HOWARD DIVISION

Partial

Baltimore National Cemetery Baltimore 23, Maryland

Washington 1000 R Street, N.W.

Elmer C. Wilson

Baltimore 17, Maryland

Sept 18 1962

Sept 18 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9966

09958

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence outside admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Catonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6611 Frederick Ave</u>		d. STREET ADDRESS <u>16611 Frederick Ave</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM E NICHALSON</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/5/83</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ret.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>unknown</u>	
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>212-09-0358</u>		17. INFORMANT <u>Mrs. Margaret Phillips</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Artery Disease</u> (a), stating the underlying cause last. DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Calcific Aortic Stenosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>July 4/10</u> 19 <u>61</u> to <u>9/22</u> 19 <u>61</u> , that (I) <u>was</u> last saw the deceased alive on <u>9/10</u> 19 <u>61</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James Nolan</u>		22b. DATE SIGNED <u>9/23/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>J S NOLAN</u>		22d. ADDRESS <u>Baltimore 29, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/25/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Toddson Park</u>	23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Nelt + Son</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 26 '61</u>	
ADDRESS <u>28</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

(M)

(1)

2362

03552

George Carter Jones

JAMES JONES
JANUARY

February 24, 1968

28

July 1968

61

after 1/1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9967

09959

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>1440</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>—</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2133 Eagle St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <u>HERBSA M. NIESZ</u>		4. DATE OF DEATH Last <u>9</u> Month <u>9</u> Day <u>9</u> Year <u>1961</u>										
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 11th 1878</u>	9. AGE (In years last birthday) <u>83</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.										
Months	Days	Hours	Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CZECHOSLOVAKIA</u>								
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>												
13. FATHER'S NAME <u>JACOB MILLER</u>			14. MOTHER'S MAIDEN NAME <u>ELIZABETH DUGANCAK</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Spring Grove State Hospital Records</u>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO (b) <u>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Chronic brain syndrome assoc. with syphilis; meningio-encephalitis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>42 1/2</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>Chronic brain syndrome assoc. with syphilis; meningio-encephalitis</u>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)							
21. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>47</u> to <u>9/9</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>9/9</u> , 19 <u>61</u> , and that death occurred <u>9/9</u> AM , from the causes and on the date stated above.												
22a. SIGNATURE <u>Bruno Radauskas</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>9/9/61</u>									
22c. PHYSICIAN'S NAME (Type) <u>BRUNO RADAUSKAS</u>		22d. ADDRESS <u>Spring Grove St. Hosp. Catonsville Md</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/12/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>	23d. LOCATION (City, town or county) <u>3801 Frederick Ave</u>	(State)								
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Courtenay</u>		ADDRESS <u>1201 Hollins St.</u>	25a. REC'D BY REGISTRAR DATE <u>SEP 11 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>								

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Hence" and "the" are faintly visible.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9968

Item 4, telephone call - Weber Funeral Home

Reg. Dist. No. 9960

1. PLACE OF DEATH a. COUNTY BALTO. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO		c. LENGTH OF STAY in 1b 60 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 934 BARDWELL RD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NORMAN BRANDT NOEL		4. DATE OF DEATH Month Day Year SEPT 4, 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1896
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY NAT. CAN. CO.	
11. BIRTHPLACE (State or foreign country) BALTO. MD		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME FRANCIS X NOEL		14. MOTHER'S MAIDEN NAME MARY CLUNK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) W.W.I.		16. SOCIAL SECURITY NO. 215-09-6005	
17. INFORMANT CATHERINE NOEL		Address 934 BARDWELL RD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V.D. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1951 , to Sept 4, 1961 , that I last saw the deceased alive on Sept 3, 1961 , and that death occurred at 7:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. C. POUND M.D.		ADDRESS (Street, city or town, state) 3325 Frederick Ave DATE SIGNED 9/5/61	
PHYSICIAN'S NAME (Type) J. C. POUND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-8-1961	22c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL CEMETERY	22d. LOCATION (City, town, or county) (State) 5301 FREDERICK AVE MD
23. FUNERAL DIRECTOR'S SIGNATURE Edward J. Weber		ADDRESS 5311 EDMONDSON AVE	
24a. REC'D BY REGISTRAR SEP 6 '61		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09961

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex (21) c. LENGTH OF STAY IN 1b Essex (21) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1640A Rickenbacker Road		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21) d. STREET ADDRESS 1640A Rickenbacker Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GERTRUDE		4. DATE OF DEATH Month Day Year September 5 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/16/13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		11. BIRTHPLACE (State or foreign country) Penna.	
10b. KIND OF BUSINESS OR INDUSTRY Clothing		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edwin Wyadt		14. MOTHER'S MAIDEN NAME Gertrude Knouse	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No --		16. SOCIAL SECURITY NO. 216-10-9515	
17. INFORMANT Joseph Nolan Rt. 3 Westminster, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) Found shot in head	
20c. TIME OF INJURY Month, Day, Year 2:15 p.m. 9/5 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . <u>Undetermined manner</u> <input checked="" type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/5/61			
ACTUAL SIGNATURE Howard Shaub EXAMINER'S NAME (Type) Howard Shaub, M.D.		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/8/61	
22c. NAME OF CEMETERY OR CREMATORY Lorriane Park Cemetery		22d. LOCATION (City, town, or country) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR James E. Bruzdinski ADDRESS 1407 Eastern Ave.		24a. REC'D BY REGISTRAR SEP 7 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Knouse			

100-100000

(M)

2000
Baltimore
Baker (2)

Baker (2)

100-100000

September 5

10

Female White

Tailor Clothing

German House

200-10-0000

Unusual wound of head

Found shoe in hand

100-100000

100-100000

100-100000

Howard Street, B.D.

100-100000

100-100000

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9970 CERTIFICATE OF DEATH 09962

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		c. LENGTH OF STAY IN 1b X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 255 Clyde Avenue		d. STREET ADDRESS 255 Clyde Avenue	
3. NAME OF DECEASED (Type or print) First IDA Middle A. Last ODEN		4. DATE OF DEATH Month Sept. Day 25 Year 19 61	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 10, 1903
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William H. White		14. MOTHER'S MAIDEN NAME Ida Dutton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Tolliver Oden		Address 255 Clyde Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the ovary DUE TO (b) with metastasis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (c) INTERVAL BETWEEN ONSET AND DEATH 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 1961 to Sept. 25, 1961 , that (I) (we) last saw the deceased alive on Sept. 25, 1961 , and that death occurred on Sept. 25, 1961 , from the causes and on the date stated above.			
22a. SIGNATURE Herbert L. Levickas		22b. ADDRESS 5305 East Drive	
22c. PHYSICIAN'S NAME (Type) Herbert L. Levickas		22d. ADDRESS 5305 East Drive	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/28/61	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City, town, or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR SEP 27 '61	
ADDRESS 4107 Wilkens Avenue		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

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William H. White

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09963

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice		d. STREET ADDRESS 406 Mt. Holly St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida Middle O'Rourke Last O'Rourke		4. DATE OF DEATH Month Sept. Day 20 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/4/1880
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR: Months 81 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Knapp		14. MOTHER'S MAIDEN NAME Dora Weber	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-32-7729	
17. INFORMANT Admission Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 199X IMMEDIATE CAUSE (a) Metastatic Ca - Adenocarcinoma DUE TO (b) Carcinoma, Primary Site Unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 1960 to Sept. 1961 , that (I) (we) last saw the deceased alive on 9/19/61 , and that death occurred at 9:25 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert Mahon		22b. DATE SIGNED A.M.	
22c. PHYSICIAN'S NAME (Type) Robert Mahon, M.D.		22d. ADDRESS 602 E. Joppa Rd. Towson 4, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-23-61	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc., 1050 York Road, Towson		25a. REC'D BY REGISTRAR DATE SEP 25 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

CERTIFICATE OF DEATH

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9972

09964

1. PLACE OF DEATH a. COUNTY BALTIMORE <div style="text-align: center; border: 1px solid black; padding: 5px; margin: 5px 0;"> Baltimore <small>MARYLAND</small> </div> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE b. COUNTY <div style="text-align: center; border: 1px solid black; padding: 5px; margin: 5px 0;"> Maryland </div> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 702 West Fayette St.	
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;"> First Robert Middle O'Rourke Last O'Rourke </div>		4. DATE OF DEATH <div style="display: flex; justify-content: space-between;"> Month September Day 23 Year 1961 </div>	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1880
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	
11. IF UNDER 24 HRS. Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		18. ADDRESS 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease (b) Generalized arteriosclerosis (c) Gene ralized arteriosclerosis </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 29, 1954 to Sept. 23, 1961 , that (I) (we) last saw the deceased alive on Sept. 23, 1961 , and that death occurred at 12:45 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 9-26-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 28-61	
23c. NAME OF CEMETERY OR CREMATORY New Catholic		23d. LOCATION (City, town or county) (State) Old Frederick Road #29	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus		25a. REC'D BY REGISTRAR SEP 29 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
9973 CERTIFICATE OF DEATH 09965														
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 41 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 23 d. STREET ADDRESS 1007 Sarah Ann Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) DAVID ----- OWENS					4. DATE OF DEATH September 6 19 61									
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1899		9. AGE (In years last birthday) 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister - Retired				10b. KIND OF BUSINESS OR INDUSTRY Religion		11. BIRTHPLACE (County & State, or foreign country) Marion, S. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.						
13. FATHER'S NAME George Owens					14. MOTHER'S MAIDEN NAME Hannah Garrison									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW I					16. SOCIAL SECURITY NO. WW I					17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE RECTUM WITH METASTASIS DUE TO (b) 154 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 27 1961 , to Sept. 6 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 6 1961 , and that death occurred at 1:30 PM , from the causes and on the date stated above.														
22a. SIGNATURE Thomas F. Crahan M.D.					22b. DATE SIGNED 9/7/61									
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.					22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-11-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland								
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson					25a. REC'D BY REGISTRAR SEP 14 '61									
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus														

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Baltimore 17, Md.

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Beltsville

Port Howard

Veterans Administration Hospital

DAVID

ORRIS

September 6

Mar 10

Mar 10

Minister - District

Holliston

Union, B. Carolina

U. S. A.

George Quinn

James Garrison

Minister Records, VAH, Beltsville Md. Veterans
Port Howard Division

Mar 1

Yes

ASSOCIATION OF THE WOMEN WITH MEMBERS

1 Year

Sept. 6

July 21

Sept. 8

1/7/61

THOMAS A. CHAMBER, M.D. VAN, FATHER AND SON, 17, HOWARD DIVISION

Harley

Beltsville National Cemetery

Beltsville Md. Maryland

Box C. Wilson Funeral Home, 1000 Broadway Ave.

Beltsville Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9974

CERTIFICATE OF DEATH

Reg. No. 9966

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 2 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 950 Fairmount Ave.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lucille Middle Myrtle Last Owens				4. DATE OF DEATH Month Sept. Day 1 Year 19 61.			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 17, 1909	
9. AGE (In years last birthday) 52 yrs.		10. AGE (In years last birthday) 52 yrs.		11. BIRTHPLACE (State or foreign country) W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady				10b. KIND OF BUSINESS OR INDUSTRY High's Ice Cream			
13. FATHER'S NAME Edward Marteny				14. MOTHER'S MAIDEN NAME Daisy Kettle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 223-36-7368			
17. INFORMANT William H. Owens				Address 950 Fairmount Ave.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacter Intestinal Hemorrhage DUE TO Coronary Artery Dis. P. Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Old ulcer DUE TO (c) Old ulcer							INTERVAL BETWEEN ONSET AND DEATH 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 1/10 , 19 61 , to 9/1 , 19 61 , that I last saw the deceased alive on 9/1 , 19 61 , and that death occurred at 5:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Victor F. King				ADDRESS (Street, city or town, state) 1102 E. Joppa Rd.			
PHYSICIAN'S NAME (Type) Victor F. King.				DATE SIGNED 9/1/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-4-1961		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Prk.		22d. LOCATION (City, town, or county) (State) Howard Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Howard Strong				ADDRESS 3207 W. North Ave.,		24a. REC'D BY REGISTRAR SEP 5 '61	
				24b. REGISTRAR'S SIGNATURE C. Howard Strong			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9975

Reg. Dist. No. 09967

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Pearce</u> Last <u>Pearce</u>		4. DATE OF DEATH Month <u>September</u> Day <u>28</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/26/09</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MACH. TOOL MFG.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John C. Pearce</u>		14. MOTHER'S MAIDEN NAME <u>Prescilla Frankie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>215-09-2855</u>	
17. INFORMANT <u>Records of Hospital</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation by hanging</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u>Suicide</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>by hanging himself by rope in chicken house on Shatz's place</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6:45</u> a. m. <u>Sept 28</u> 19 <u>61</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Catonsville</u>		20f. (City or town) (County) (State) <u>Catonsville Balto Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo S. M. Kieffer</u>		DATE SIGNED <u>61</u>	
EXAMINER'S NAME (Type) <u>George S. M. Kieffer M.D.</u>		DEPUTY MEDICAL EXAMINER <u>1010 Leeds Ave. Sept. 28</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT. 21, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WAUGH CHAPEL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>GLEN ARM, BALTO. CO., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN BURNS' SONS, Towson, MD.</u>		24a. REC'D BY REGISTRAR <u>OCT 5 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9976

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09968

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATON VILLAGE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CATON RIDGE NURSING HOME				d. STREET ADDRESS 601 S MILTON AVE			
3. NAME OF DECEASED (Type or print) First NIKITA Middle PERKOWETZ Last PERKOWETZ				4. DATE OF DEATH Month SEPT Day 22 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 14 1885	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.		IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY BOX FACTORY		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? 1ST PAPERS							
13. FATHER'S NAME PAUL PERKOWETZ				14. MOTHER'S MAIDEN NAME UNK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. ---		17. INFORMANT Address IRENE PERKOWETZ 1730 E 30TH ST	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450-0 DUE TO Cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis generalized DUE TO Unknown (c) Chronic PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Dehydration & Electrolyte Imbalance							INTERVAL BETWEEN ONSET AND DEATH 3 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 15, 1961 , to Sept. 22, 1961 , that (I) (we) last saw the deceased alive on Sept 19, 1961 , and that death occurred at 7 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE Cliff Ratliff				22b. DATE SIGNED 9/23/61		22c. PHYSICIAN'S NAME (Type) CLIFF RATLIFF, JR.	
22d. ADDRESS 4605 EDMONDSON AVE				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT 25 61		23c. NAME OF CEMETERY OR CREMATORY ST ANDREW CEM.		23d. LOCATION (City, town, or county) (State) GERMAN HILL RD MD	
24. FUNERAL DIRECTOR'S SIGNATURE Slippel Bros				25a. REC'D BY REGISTRAR SEP 25 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kane	
ADDRESS 1800 E LOMBARD ST				DATE			

03558

CERTIFICATE OF DEATH

1971

STATE OF TEXAS

(4)

(1)

1971

DECEASED

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "DECEASED" and "1971" are visible.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

9977 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09969

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1213 62nd Street, Balto. - 6		c. LENGTH OF STAY IN 1b Dr. Baumgardner's Office, Golden Ring Rd.		2. USUAL RESIDENCE (Where deceased lived, If institution: State and give nearest town) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1213 62nd Street, Balto - Rt. #7		d. STREET ADDRESS Same as above		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JIMMY		First EDWARD		Middle PEYTON		Last PEYTON		4. DATE OF DEATH 9 25 1961		Month 9		Day 25		Year 1961	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-5-1961		9. AGE (In years) 1 1/2		IF UNDER 1 YEAR Months 12		Days 10		IF UNDER 24 HRS. Hours 12 Min. 40	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME JOANNA PEYTON		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT JOANNA PEYTON		Address 1213 62nd St. Balto., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 772.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Nutritional difficulty DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombosis of left internal cerebral vein.												INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Howard G. Shaub		M.D. H OWARD G. SHAUB, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9-25-61							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-27-61		22c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.		22d. LOCATION (City, town, or country) BALTO., MD.		(State)							
23. FUNERAL DIRECTOR Lissahn Sunil Home 7401 Belair Rd.		ADDRESS 2048211X15		24a. REC'D BY REGISTRAR SEP 28 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna									

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E. M. STANGE, D. CHAND, P.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9978

09970

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>34 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				e. STREET ADDRESS <u>8 Locust Street</u>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM W. PHIBBONS</u>				4. DATE OF DEATH Month <u>September</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 30, 1918</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Station Attendant</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lothian, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Early M. Phibbons</u>				14. MOTHER'S MAIDEN NAME <u>Ethel E. Wayson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u> <u>WW-11</u>				16. SOCIAL SECURITY NO. <u>217-16-8559</u>			
17. INFORMANT <u>Clinical Records, VA Hospital</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE DUE TO MITRAL STENOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>RHEUMATIC HEART DISEASE</u> DUE TO (c) <u>CEREBRAL EMBOLISM AND PULMONARY EMBOLI</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.		20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County)		20g. (State)		21. I certify that (IX) (this hospital) attended the deceased from <u>August 5, 1961</u> to <u>September 8, 1961</u> that (II) (we) last saw the deceased alive on <u>Sept. 8, 1961</u> , and that death occurred at <u>11:20 A.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>John D. Talbert</u>				22b. DATE SIGNED <u>9-9-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOHN D. TALBERT</u>				22d. ADDRESS <u>VAH Baltimore Md - Ft. Howard Division</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-11-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Zion Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Anne Arundel County, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight Inc</u>				25a. REC'D BY REGISTRAR <u>SEP 13 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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John A. Bunker

JOHN A. BUNKER

1911-12

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9979

09971

1. PLACE OF DEATH o. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b 4Yrs.16Mos.10D		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION THE SHEPPARD AND ENOCH PRATT HOSPITAL				d. STREET ADDRESS 1107 St. Paul Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle William Last Pierson				4. DATE OF DEATH Month September Day 5 Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1883		9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Medicine		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Noah Robert Pierson				14. MOTHER'S MAIDEN NAME Mary McNabb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 422.1 DUE TO Pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) Chronic myocarditis DUE TO (c) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH Term 5 da 5 hr +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome = C.A.S.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 25, 1956 to Sept 5, 1961 , that (I) (we) last saw the deceased alive on Sept 5, 1961 , and that death occurred at 2:45 PM , from the causes and on the date stated above.							
22a. SIGNATURE W.W. Elgin		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE September 5, 1961			
22c. PHYSICIAN'S NAME (Type) W. W. Elgin, M. D.		22d. ADDRESS Towson 4, Maryland The Sheppard and Enoch Pratt Hospital,					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9-8-61		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City, town, or county) (State) Pikesville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. 4905 York Rd. Balto				25a. REC'D BY REGISTRAR SEP 7 '61		25b. REGISTRAR'S SIGNATURE —	

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OFFICE OF THE ATTORNEY GENERAL

1938

1938

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1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>439 Rocky Point Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Effie</u> First <u>E</u> Middle <u>Porter</u> Last		4. DATE OF DEATH <u>Sept</u> Month <u>29</u> Day <u>1961</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-10-1889</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Tutchton</u>		14. MOTHER'S MAIDEN NAME <u>Jane Stevenson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-42-6981</u>	
17. INFORMANT <u>Charles Porter</u> Address <u>Box 439 Rocky Pt Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular apoplexy.</u> 422.01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic Cardio-Vascular disease 5 yrs</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> 19 <u>61</u> , to <u>Sept 29</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Sept 30</u> 19 <u>61</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>J. M. Baumgardner</u> M.D.		22b. DATE SIGNED <u>10/2/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Balto 6 Md.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-3-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Balto, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>For Mrs. Jane Porter 401 Balto Rd.</u>		25a. REC'D BY REGISTRAR <u>Oct 5 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9981

CERTIFICATE OF DEATH

09973

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, residence prior to admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riderwood				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riderwood			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1711 Roland Avenue				d. STREET ADDRESS 1711 Roland Avenue			
3. NAME OF DECEASED (Type or print) CHARLES JAMES PRICE				4. DATE OF DEATH Month September Day 22 Year 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1911		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months 50 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Burton Price			
14. MOTHER'S MAIDEN NAME Amanda J. Miller				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II 219-07-9103 Family records			
16. SOCIAL SECURITY NO. 219-07-9103				17. INFORMANT Family records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of left lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from 4/27/1961 to 9/22/1961 , that (I) (we) last saw the deceased alive on 9/20/1961 , and that death occurred at 8 P.M. from the causes and on the date stated above.							
22a. SIGNATURE M. K. Quinn M.D.				22b. DATE SIGNED 9/26/61			
22c. PHYSICIAN'S NAME (Type) M. KEVIN QUINN				22d. ADDRESS 1927 YORK RD, TIMONIUH Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 26, 1961		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial		23d. LOCATION (City, town or county) (State) Cockeysville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland				25a. REC'D BY REGISTRAR DATE SEP 28 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1981



Bellevue

Bellevue

00870

Bellevue

156 Wood

156 Wood

1711 Roland Avenue

1711 Roland Avenue

CHARLES JAMES PRICE

September 23, 1981

1

x

20

July 28, 1981

White

White

Clark

Clark

Clark

USA

Barton Price

Barton Price

Yes

Yes

Yes

Continuation of 10/1/81

M. Kevin Quinn
M. K. Quinn
10/1/81

10/1/81

10/1/81

10/1/81

John Burns' Sons, Townson, Maryland

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
VR A15 (4)
15M 9/60

9982
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
99974

CERTIFICATE OF DEATH

Item 23b, Film G295 9/21/61 iwk

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 41 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore 30 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2352 Annapolis Avenue d. STREET ADDRESS 3V01-4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MELVIN G. QUEEN First Middle Last		4. DATE OF DEATH September 13 1961 Month Day Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1919 42 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY County Sanitation	9. AGE (In years last birthday) 42 Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Severn, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Rufus Queen		14. MOTHER'S MAIDEN NAME Columbine Oliver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 214-12-2099	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM 465 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF ESOPHAGUS, POST OPERATIVE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation 8/31/61 Esophageal Gastrectomy-Carcinoma of esophagus INTERVAL BETWEEN ONSET AND DEATH 15 MINUTES UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from August 3, 1961 to September 13, 1961 , that (2) (we) last saw the deceased alive on Sept. 13, 1961 , and that death occurred at 6:15 A.M., from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Crahan M.D.		22b. DATE SIGNED 9/13/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTIMORE 18 MD., FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/15/51	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. Baltimore 28, Maryland	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home, 1631 Druid Hill Ave., Balto. Md.		25a. REC'D BY REGISTRAR SEP 19 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9983

09975

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<u>1730 E. Joppa Road</u>				<u>1730 E. Joppa Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph</u> <u>Clarence</u> <u>Ray</u>				4. DATE OF DEATH Month Day Year <u>Sept.</u> <u>25</u> <u>19 61</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-11-1900</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>HOWARD G. RAY</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH FUCHS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>215-03-6176</u>			
17. INFORMANT <u>CATHERINE RAY</u>				Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>199X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO <u>Generalized Carcinomatosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this physician) attended the deceased from <u>Oct 9-22 1961</u> to <u>Sept 25 1961</u> , that (I) () last saw the deceased alive on <u>9-22 1961</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph F. Hilpin</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/25/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph F. Hilpin</u>				22d. ADDRESS <u>8400 Hoch Raven Blvd. Balto 4, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>BURIAL</u>		<u>9/27/61</u>		<u>Holy Redeemer</u>		<u>BALTIMORE Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Rd.</u>		25a. REC'D BY REGISTRAR <u>SEP 26 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



[Faint handwritten text at the bottom of the page]

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27290

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FOR STATE HEALTH DEPT. M
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9984 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13 & 14 film G297 10/9/61 iwk

09976

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>STONLEIGH.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>STONLEIGH.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>610 KINGSTON RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CONRAD J. RETHSCHULTE</u>		4. DATE OF DEATH <u>Sept 25</u> 19 <u>61</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/12/1904</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Frederick H. Rethschulte</u>		14. MOTHER'S MAIDEN NAME <u>Fredericka Schneider</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>2-5-10-8522</u>	
17. INFORMANT <u>WIFE</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Coronary Insufficiency</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>2 yr</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Cholet O'Donnell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/28, 61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>BALTO Co</u>	
23. FUNERAL DIRECTOR <u>R. Heermann</u>		ADDRESS <u>6067 HARFORD RD</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	
DATE <u>SEP 28 '61</u>			

OUR STATE
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1852

CERTIFICATE OF DEATH

Reg. Dist. No. 055

9985

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 906 Edmondson Ave		d. STREET ADDRESS 906 Edmondson Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EMMA		4. DATE OF DEATH Month Sept Day 12 Year 1961	
5. SEX Female		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 28, 1881	
9. AGE (In years last birthday) yrs. 80		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		12. KIND OF BUSINESS OR INDUSTRY Maryland	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME ? Brodus		16. MOTHER'S MAIDEN NAME Fannie ?	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		18. SOCIAL SECURITY NO. ?	
19. INFORMANT Mrs Lillian Houston		20. ADDRESS 906 Edmondson Ave.	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral Insufficiency DUE TO (b) Hypertensive Arteriosclerotic Heart Disease ? DUE TO (c) ?			
22. INTERVAL BETWEEN ONSET AND DEATH 8 Months & 12 Days			
23. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ulcer of the Right Foot.			
24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		25b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
26a. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		26b. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
26c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26d. (City or town) (County) (State)	
27. I certify that I attended the deceased from Jan. 3rd, 1961 , to Sept. 12th, 1961 , that I last saw the deceased alive on Sept. 12th, 1961 , and that death occurred at 6.30 A.M. , from the causes and on the date stated above.			
28. ACTUAL SIGNATURE C. F. Maloney, M.D.		29. ADDRESS (Street, city or town, state) DATE SIGNED 57 Winters Lane 9/12/61	
30. PHYSICIAN'S NAME (Type) C. F. Maloney, M.D.		31. Catonsville, 28. Md.	
32a. BURIAL, CREMATION, REMOVAL (Specify) Burial		32b. DATE THEREOF 9-16-61	
32c. NAME OF CEMETERY OR CREMATORY Johnsville, Md.		32d. LOCATION (City, town, or county) (State)	
33. FUNERAL DIRECTOR'S SIGNATURE Mr. Frank W. Hummel		34. ADDRESS 578 W. Bidder St.	
35. REC'D BY REGISTRAR SEP 15 '61		36. REGISTRAR'S SIGNATURE Arthur L. Kneale	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

1952

(M)

and

Residence

105 Kensington

105 Kensington Ave.

Age

45 years

Occupation

Operator, Western Electric

Married

Married

Spouse

Spouse

105 Kensington Ave.

105 Kensington Ave.

105 Kensington Ave.

105 Kensington Ave.

105 Kensington Ave.

105 Kensington Ave.

105 Kensington Ave.

105 Kensington Ave.

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105 Kensington Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9986 Item 23b, Film G-295 9/18/61 iwk 09978											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard						c. LENGTH OF STAY IN 1b 46 days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
3. NAME OF DECEASED (Type or print) AUGUSTUS RICHTER						4. DATE OF DEATH September 8 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 25, 1871 89		9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Runner				10b. KIND OF BUSINESS OR INDUSTRY Broker's Office				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick W. Richter						14. MOTHER'S MAIDEN NAME Louisa Busch					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes SAW						16. SOCIAL SECURITY NO. 217-22-3785					
17. INFORMANT Clinical Records, VA Hospital						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF PROSTATE (c) GENERALIZED ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gastric Uloer					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 48 HOURS UNKNOWN UNKNOWN					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 24 1961 , to Sept 8 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept 8 1961 , and that death occurred at 8:15 P.M. from the causes and on the date stated above.											
22a. SIGNATURE John D. Talbert M.D.						22b. DATE SIGNED 9-9-61					
22c. PHYSICIAN'S NAME (Type) John D. Talbert, M.D.						22d. ADDRESS VAH Baltimore Md - Ft Howard Division					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9/8/61			23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery			23d. LOCATION (City, town or county) (State) Baltimore Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Lasshan Funeral Home						25a. REC'D BY REGISTRAR SEP 14 '61					
25b. REGISTRAR'S SIGNATURE Charles L. Hanna											

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John D. Roberts, N.Y.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 9979

9987

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Wash. Baltimore</u> c. LENGTH OF STAY IN 1b <u>Lifetime</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6711 Timberridge Rd., Baltimore 9 Md.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balt.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Co.</u> d. STREET ADDRESS <u>6711 Timberridge Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joshua</u> First <u>OLIVER</u> Middle <u>Ritter</u> Last		4. DATE OF DEATH <u>Sept. 17</u> Month <u>17</u> Day <u>1961</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 13, 1871</u> 9. AGE (In years last birthday) <u>89</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmhand</u>	11. BIRTHPLACE (State or foreign country) <u>Balti. Co., Md.</u>
13. FATHER'S NAME <u>Oliver Ritter</u>		14. MOTHER'S MAIDEN NAME <u>Julia Ann Keller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-03-587</u>	
17. INFORMANT <u>Mrs. Sarah C. Ritter, 6711 Timberridge Rd.</u>		Address <u>Baltimore 9 Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, liver</u> 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertrophy prostate</u> DUE TO (c) <u>Arteriosclerosis, general</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2 Jan</u> , 1956, to <u>9-12</u> , 1961, that I last saw the deceased alive on <u>9-12</u> , 1961, and that death occurred at <u>?</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles V. Williams</u>		ADDRESS (Street, city or town, state) <u>1632 Reisterstown Road</u>	
PHYSICIAN'S NAME (Type) <u>Charles H. Williams</u>		DATE SIGNED <u>Pikesville 8, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 19, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Suters Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Lutherville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		ADDRESS <u>Pikesville 8, Md.</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Harris</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	
DATE <u>OCT 2 '61</u>			

MEDICAL CERTIFICATION

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
Released by Medical Examiner Dr. P. D. Caplan
Unannounced dead by Dr. Stephen Haplow

CERTIFICATE OF DEATH

0027

JAMES BROWN

AND CONSENT

IN THE

OF

THE

STATE

OF

MARYLAND

DEPARTMENT OF HEALTH

BALTIMORE

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TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

9988

09980

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENWOOD				c. LENGTH OF STAY IN 1b 36 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7410 KENLEA AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LENA Middle ROBIE Last ROBIE				4. DATE OF DEATH Month SEPT Day 16 Year 1961			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 14, 1890		9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEWING		10b. KIND OF BUSINESS OR INDUSTRY SEWING		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ANDREW LEWIS				14. MOTHER'S MAIDEN NAME DOROTHY KOHLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 213-09-2677B		17. INFORMANT Address FREDERICK ROBIE 7410 KENLEA AVE #6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 5 yrs						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1961 to 9/16, 1961 , that (I) (we) last saw the deceased alive on 9/15, 1961 , and that death occurred at 5:57 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Banngardner M.D.				22b. DATE SIGNED 9/18/61		22c. PHYSICIAN'S NAME (Type) Balto 6 Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/19/1961		23c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Road #6 MD.				25a. REC'D BY REGISTRAR DATE SEP 19 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 24 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. COUNTY Maryland b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore c. STREET ADDRESS 1110 Druid Hill Avenue d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) PATRICK		First ---		Middle ---		Last ROBINSON		4. DATE OF DEATH Month September Day 21 Year 1961							
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH March 17, 1897		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 64 Days 64 Hours 64 Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Trucking				11. BIRTHPLACE (County & State, or foreign country) Darlington, S. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Jeff Robinson				14. MOTHER'S MAIDEN NAME Serena Charles				17. INFORMANT Address Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I				16. SOCIAL SECURITY NO. 214-14-2436				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO (b) Arteriosclerosis DUE TO (c) Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		20g. (County) Baltimore		20h. (State) Md.			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 28, 1961 to September 21, 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 21, 1961 , and that death occurred at 9:00 P.M. from the causes and on the date stated above.															
22a. SIGNATURE Frederick S. Donaldson M.D.				22b. DATE 9/22/61				22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9-26-61				23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.				23d. LOCATION (City, town or county) Baltimore 28, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson, 1000 Brantley Avenue, Balto. 17, Md.				25a. REC'D BY REGISTRAR SEP 27 '61				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 20</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balta Co, md. (Middle River)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>19 Harrison St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>C.</u> Last <u>Rosier</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15 1885</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u> Hours <u>15</u> Min. <u>00</u>	IF UNDER 24 HRS. Hours <u>15</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna. Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lewis Rosier</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Riley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>717-078978</u>	
17. INFORMANT <u>Lawrence L. Rosier, Rt. 16, Box 11, Balto, Md.</u>		Address <u>Rt. 16, Box 11, Balto, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart dis</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/5</u> , 19 <u>61</u> , to <u>9/4</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>9/4</u> , 19 <u>61</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Stablersville Cemetery, Parkton, Md.</u> DATE SIGNED <u>SEP 11 '61</u>			
ACTUAL SIGNATURE <u>Leonard Paul Berger, M.D.</u>		PHYSICIAN'S NAME (Type) <u>Leonard Paul Berger, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-8-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stablersville Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Parkton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Rosenbaum, New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>SEP 11 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9991 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09983

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Liberty Rd</i>		c. LENGTH OF STAY IN 1b <i>36 yrs</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>X Randallstown, Md</i>		d. STREET ADDRESS <i>1 Liberty Rd</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Randallstown</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>JOHN KLOHR RUFF</i>				4. DATE OF DEATH Month Day Year <i>Sept. 15 1961</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 9, 1891</i>		9. AGE (In years last birthday) <i>70</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>General Contractor Construction</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Balto.</i>		11. BIRTHPLACE (State or foreign country) <i>M.S.A.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Seymour Ruff</i>				14. MOTHER'S MAIDEN NAME <i>Wilhelmina Klorh</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-10-7235</i>		17. INFORMANT <i>Marg. Ruff - Randallstown, Md</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Drowning (Suicide)</i> <i>975X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Depressive</i> (c) <i>Depressive</i> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> <i>3 yrs.</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none. Accused found in Private Pool</i>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>Sept 15, 61</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Private Pool</i>		20f. (City or town) (County) (State) <i>Randallstown Balto. Md</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>D. D. Caples</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>D. D. CAPLES</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <i>Randallstown, Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Entombment</i>		22b. DATE THEREOF <i>9/18/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olive</i>		22d. LOCATION (City, town, or country) (State) <i>Randallstown, Maryland</i>	
23. FUNERAL DIRECTOR <i>Living Beyer</i>		ADDRESS <i>8728 Liberty Road Randallstown, Md.</i>		24a. REC'D BY REGISTRAR <i>SEP 21 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

MEDICAL CERTIFICATION

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2001 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE
PUBLIC HEALTH

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(1)

San Francisco, California

W. J. ...
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FOR STATE
HEALTH DEPT. **M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MARYLAND STATE DEPARTMENT OF HEALTH
9992 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Balto</i>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Right to Burial Mission) e. STATE <i>md.</i> b. COUNTY <i>Balto</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Randallstown</i>		c. LENGTH OF STAY in lb <i>2.5 yrs</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Randallstown, Md.</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>3332 Offutt Rd.</i>				e. STREET ADDRESS <i>1 3332 Offutt Rd.</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MARGUARITE T. RUND</i>				4. DATE OF DEATH <i>Sept 14 1961</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb-19, 1966</i>		9. AGE (In years last birthday) <i>55 yrs.</i>	IF UNDER 1 YEAR Months <i>14</i> Days <i>14</i>	IF UNDER 24 HRS. Hours <i>19</i> Min. <i>61</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Balto, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Wm Schultheris</i>			14. MOTHER'S MAIDEN NAME <i>Mary Stockman</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>			16. SOCIAL SECURITY NO. <i>No.</i>		17. INFORMANT <i>Wm J. Rund - 3332 Offutt Rd.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <i>None</i> DUE TO (c) <i>None</i>							INTERVAL BETWEEN ONSET AND DEATH <i>14 hrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <i>None</i>			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>None</i> p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>D.D. Catles</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>9-14-61</i>	
EXAMINER'S NAME (Type) <i>D.D. CATLES</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-16-1961</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Lake View Memorial</i>		22d. LOCATION (City, town, or county) (State) <i>Carroll Co. Md.</i>	
23. FUNERAL DIRECTOR <i>Spring Byers 87282 Baltimore</i>				24a. REC'D BY REGISTRAR <i>SEP 15 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krantz</i>	
				Address <i>Randallstown, Md.</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9993

CERTIFICATE OF DEATH

09985

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore City		
c. LENGTH OF STAY in 1b 6yrlmth9dys			d. STREET ADDRESS 3308 Sumter Avenue		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL					
3. NAME OF DECEASED (Type or print) Esther			4. DATE OF DEATH Month September Day 29 Year 1961		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH *JUNE 17, 1900	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (County & State, or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Louis Sachs		
14. MOTHER'S MAIDEN NAME Sarah Cablinski			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown no		
16. SOCIAL SECURITY NO. unknown no			17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 593X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonitis					INTERVAL BETWEEN ONSET AND DEATH 7 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that to (this hospital) attended the deceased from Aug. 17, 1955 , to Sept. 29, 1961 , that (I) (we) last saw the deceased alive on Sept. 29, 1961 , and that death occurred at 3:20 P.M. from the causes and on the date stated above.					
22a. SIGNATURE H. J. Cholmondeley M.D.			22b. DATE SIGNED Sept. 29, 1961		
22c. PHYSICIAN'S NAME (Type) H. J. Cholmondeley			22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 1/61	23c. NAME OF CEMETERY OR CREMATORY Beth Jacob (Vecair)		23d. LOCATION (City, town or county) (State) Rosedale, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & SONS, INC. - 6010 REISTERSTOWN RD.			25a. REC'D BY REGISTRAR OCT 4 '61		
25b. REGISTRAR'S SIGNATURE Arthur L. Thaw					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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9994
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN b 47 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) None				2. USUAL RESIDENCE (Where deceased lived, if institution; last residence prior to admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills d. STREET ADDRESS Black Forest Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Darows		First		Middle		Last		4. DATE OF DEATH Sept. 16, 1961	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 18, 1913		9. AGE (In years last birthday) 47 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Dairy		11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George H. Schaeffer				14. MOTHER'S MAIDEN NAME Edith Mae Poe				Address Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II		17. INFORMANT Mrs. Irene M. Schaeffer, Owings Mills,		Address Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 hours									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		20g. (County) Baltimore	
21. I certify that (I) (this hospital) attended the deceased from Sept 16, 1961 , to Sept 16, 1961 , that (I) (we) last saw the deceased alive on Sept 16, 1961 , and that death occurred at 8:15 M, from the causes and on the date stated above.									
22a. SIGNATURE Martin J. Feldman M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/17/61			
22c. PHYSICIAN'S NAME (Type) Martin J. Feldman				22d. ADDRESS #1 Cherry Hill Rd, Pikesville, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 19, 1961		23c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore County, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Henry James Echhardt				ADDRESS Owings Mills, Md.		25a. REC'D BY REGISTRAR SEP 19 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Harris	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9995

CERTIFICATE OF DEATH

Reg. Dist. No. 09988

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore 18	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN lb 6 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armcast Nursing Home		d. STREET ADDRESS 1724 Chilton Street	
3. NAME OF DECEASED (Type or print) First CORA Middle Katherine Last Schwartz		4. DATE OF DEATH Month Sept. Day 27 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EMELIUS Miller		14. MOTHER'S MAIDEN NAME Mary Meyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 162 01 4612	
17. INFORMANT Mr. Charles H. Schwartz.		17a. ADDRESS 1724 Chilton Street Balto. 18, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular haem. DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4CVD DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous CVA & R. hemiplegia.			INTERVAL BETWEEN ONSET AND DEATH 10 min. years.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-26-61 , 19__, to 9-24-61 , 19__, that I last saw the deceased alive on 9-24-61 , 19__, and that death occurred at 12:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11 East Chase Street, Baltimore 2, Md. DATE SIGNED 9/28/61			
ACTUAL SIGNATURE Philip Whittlesey M.D.		PHYSICIAN'S NAME (Type) PHILIP WHITTLESEY, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/30/61	
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTO. MD.		24a. REC'D BY REGISTRAR OCT 2 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Knapp			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF REVENUE

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9996

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G294 9/11/61 mh

Reg. Dist. No. 99989

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5559 Oakland Road</u>		d. STREET ADDRESS <u>5559 Oakland Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Anna A. Shepp</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 20, 1918</u>
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u>43</u> Days <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James J. Collins</u>		14. MOTHER'S MAIDEN NAME <u>Antionette R. Koch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>212-09-5135</u>	
17. INFORMANT <u>Edward C. Shepp</u>		Address <u>5559 Oakland RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation by Laundryplastic bag</u> <u>974X</u> DUE TO <u>Bag tied over head by a piece of cord</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <u>(Suicide)</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had been in bad health</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Tied a plastic bag over her head and face, in her bed</u>	
20c. TIME OF INJURY Month, Day, Year <u>4-30 a.m. Sep. 1, 61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Halethorpe Balto. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1010 Leeds Ave</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/5/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard, 4107 Wilkens Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 6 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(M)

NAME OF DECEASED		SEX		AGE		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		PROGNOSIS		HISTORY		FAMILY HISTORY		SOCIAL HISTORY	
SIGNATURE OF MEDICAL EXAMINER		DATE		PLACE		CITY		STATE		COUNTRY		DATE		TIME		PLACE	
SIGNATURE OF WITNESS		DATE		PLACE		CITY		STATE		COUNTRY		DATE		TIME		PLACE	
SIGNATURE OF JURY		DATE		PLACE		CITY		STATE		COUNTRY		DATE		TIME		PLACE	
SIGNATURE OF JUDGE		DATE		PLACE		CITY		STATE		COUNTRY		DATE		TIME		PLACE	
SIGNATURE OF CLERK		DATE		PLACE		CITY		STATE		COUNTRY		DATE		TIME		PLACE	
SIGNATURE OF NOTARY		DATE		PLACE		CITY		STATE		COUNTRY		DATE		TIME		PLACE	
SIGNATURE OF ATTORNEY		DATE		PLACE		CITY		STATE		COUNTRY		DATE		TIME		PLACE	
SIGNATURE OF SHERIFF		DATE		PLACE		CITY		STATE		COUNTRY		DATE		TIME		PLACE	
SIGNATURE OF CONSTABLE		DATE		PLACE		CITY		STATE		COUNTRY		DATE		TIME		PLACE	
SIGNATURE OF JURY		DATE		PLACE		CITY		STATE		COUNTRY		DATE		TIME		PLACE	
SIGNATURE OF JUDGE		DATE		PLACE		CITY		STATE		COUNTRY		DATE		TIME		PLACE	
SIGNATURE OF CLERK		DATE		PLACE		CITY		STATE		COUNTRY		DATE		TIME		PLACE	
SIGNATURE OF NOTARY		DATE		PLACE		CITY		STATE		COUNTRY		DATE		TIME		PLACE	
SIGNATURE OF ATTORNEY		DATE		PLACE		CITY		STATE		COUNTRY		DATE		TIME		PLACE	
SIGNATURE OF SHERIFF		DATE		PLACE		CITY		STATE		COUNTRY		DATE		TIME		PLACE	
SIGNATURE OF CONSTABLE		DATE		PLACE		CITY		STATE		COUNTRY		DATE		TIME		PLACE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

09990

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>7mth20dys</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1227 Hesse Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>Adeline Shoemaker</u>				4. DATE OF DEATH September 1 1961			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 25, 1913</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Georgett Herbert</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Spath</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Herbert Shoemaker - 1227 Hesse Ave. Baltimore</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Myocardial degeneration and replacement fibrosis</u> Conditions, if any, which gave rise to immediate cause (c) <u>Schizophrenic reaction, paranoid type</u> (e), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Jan. 11, 1961</u> to <u>Sept. 1, 1961</u> that (I) (we) last saw the deceased alive on <u>Sept. 1, 1961</u> , and that death occurred at <u>3:00 a.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Stella Wachslar</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>9-1-61</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				22d. ADDRESS <u>Spring Grove State Hospital Catonsville 28, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-4-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Golden Ring Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lochner Funeral Home</u>				25a. REC'D BY REGISTRAR <u>SEP 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

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State the letter

San Francisco 7th March 18

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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9998

CERTIFICATE OF DEATH

09991

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 21 Mo. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1033 Marksworth Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Balto. d. STREET ADDRESS 1033 Marksworth Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Smith Middle Edward Last Singhass		4. DATE OF DEATH Month Sept. Day 11 Year 19 61	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1883
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired auto Mechanic, Atlantic Coast		10b. KIND OF BUSINESS OR INDUSTRY First BIRTHPLACE (County & State, or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Singhass	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) 215-05-1610	
16. SOCIAL SECURITY NO. 215-05-1610		17. INFORMANT Mrs Henry Iager, 1033 Marksworth Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC Cardio 422.1 DUE TO vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) 1 YR + (c) 1 YR +		INTERVAL BETWEEN ONSET AND DEATH 1 YR +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2 AM , 19 61 to 9/11 , 19 61 that (I) (we) last saw the deceased alive on 9/10 , 19 61 , and that death occurred at 3 AM , from the causes and on the date stated above.			
22a. SIGNATURE Thos E Roach M.D.		22b. DATE SIGNED 9/12/61	
22c. PHYSICIAN'S NAME (Type) Thos E Roach		22d. ADDRESS 5530 Balto Nat'l Pike - 28	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/13/61	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemty.	23d. LOCATION (City, town or county) (State) Randallstown Md.
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR SEP 14 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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09992

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Rural and urban, if institution) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>4mth2dys</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Maggie</u>		First <u>J.</u> Middle <u>Slooman</u> Last <u>Slooman</u>		4. DATE OF DEATH <u>Sept 17 1961</u>		Month <u>Sept</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 1, 1888</u>	
9. AGE (In years, last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>unknown</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypostatic pneumonia</u> (c) <u>Circulatory disturbances</u> <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 3, 1961</u> to <u>Sept 17, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 17, 1961</u> , and that death occurred at <u>3:25 PM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Jose R. Arizaga, M.D.</u>		22b. DATE SIGNED <u>Sept 17, 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>JOSE R. ARIZAGA, M.D.</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSE R. ARIZAGA, M.D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-20-61</u>		23b. DATE THEREOF <u>4-20-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-20-61</u>		23b. DATE THEREOF <u>4-20-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cider Hill</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>McLaney - 130 E Fort Ave.</u>		25a. REC'D BY REGISTRAR <u>SEP 19 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. REGISTRAR'S SIGNATURE <u> </u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
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09993											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; if not, last place of residence) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard						c. LENGTH OF STAY IN lb 109 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						e. STREET ADDRESS 1728 Presbury Street					
3. NAME OF DECEASED (Type or print) LEROY SMITH						4. DATE OF DEATH September 17 1961					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 11, 1895		9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Construction				11. BIRTHPLACE (County & State, or foreign country) Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Austin Smith						14. MOTHER'S MAIDEN NAME Ada Britton					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-1						16. SOCIAL SECURITY NO. 217-09-5935					
17. INFORMANT Clinical Records, VA Hospital						18. ADDRESS Baltimore 18, Maryland-FORT HOWARD DIVISION					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANAPLASTIC CARCINOMA, LEFT LUNG WITH WIDESPREAD METASTASIS 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) ABSCCESS, LEFT LUNG; DIABETES MELLITUS; ARTERIOSCLEROSIS, GENERALIZED										INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 31 1961 , to Sept 17 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept 17 1961 , and that death occurred at 10:00 A.M. from the causes and on the date stated above.											
22a. SIGNATURE C. M. Snyder M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 9-17-61		
22c. PHYSICIAN'S NAME (Type) C. M. SNYDER M.D.						22d. ADDRESS VAH Baltimore Md - Ft Howard Division					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-21-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery				23d. LOCATION (City, town or county) (State) Baltimore Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE George C. Nelson				ADDRESS 1346 N. Calhoun St Baltimore, Maryland				25a. REC'D BY REGISTRAR SEP 19 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10001

Reg. Dist. No.

09994

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CARNEY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9437 Ridgely Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret</u> First <u>May</u> Middle <u>Smith</u> Last		4. DATE OF DEATH Month <u>Sept.</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-23-1884</u> 77 yrs.
9. AGE (In years last birthday) <u>77</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u>	11. IF UNDER 24 HRS. Hours <u>7</u> Min. <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William R. RYAN</u>		14. MOTHER'S MAIDEN NAME <u>MARY A. MAHARER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>MRS LEONARD BAUBLITY SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> to <u>Sept 9, 1961</u> , that I last saw the deceased alive on <u>Sept 9, 1961</u> , and that death occurred at <u>9 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald Jandoy</u> M.D.		ADDRESS (Street, city or town, state) <u>6077 Harford Rd</u> DATE SIGNED <u>9-9-61</u>	
PHYSICIAN'S NAME (Type) <u>R Donald Jandoy</u>		<u>Balto. 14, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/13/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Belair Mem.</u>	22d. LOCATION (City, town, or county) (State) <u>Belair Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. RUCK</u> ADDRESS <u>5305 HARFORD RD.</u>		24a. REC'D BY REGISTRAR <u>SEP 13 '61</u>	24b. REGISTRAR'S SIGNATURE <u>William L. Hume</u>

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10002
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH *Item # 8 - Baltimore City B.C.*

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ching Mills</i>		c. LENGTH OF STAY IN 1b <i>4 MONTHS</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rosewood State Training School</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>John Toy Snyder</i>		4. DATE OF DEATH Month Day Year <i>September 12 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-29-61</i>
9. AGE (In years lost birthday) yrs. <i>4</i> Months <i>13</i> Days <i>+</i> Hours <i>+</i> Min. <i>+</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland (Baltimore City)</i>		12. CITIZEN OF WHAT COUNTRY? <i>W.S.A.</i>	
13. FATHER'S NAME <i>Richard Andrews Snyder</i>		14. MOTHER'S MAIDEN NAME <i>Bettie Howell Thomas</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Rosewood Records</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia complicating hydro-cephalus.</i> 344.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Blumie</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	23b. DATE THEREOF <i>Sept 14 1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Green Mount Cem.</i>	23d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>J.F. Eline & Sons</i>		25. REC'D BY REGISTRAR <i>SEP 18 '61</i>	
ADDRESS <i>Reisterstown Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10003
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4400 Kenwood Ave				d. STREET ADDRESS 26 S. Highland Ave/			
3. NAME OF DECEASED (Type or print) CARRIE		First CARRIE		Middle JOHN		Last SOUDERS	
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 26, 1879	
9. AGE (In years lost birthday) 81 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Barton				14. MOTHER'S MAIDEN NAME Margaret Glacrin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Georgiana Greenwood 4400 Kenwood			
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis. Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Arteriosclerotic Cardio-Vascular Disease (c) Cardiac Insufficiency. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Insufficiency. INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 8/7, 1961 to 8/24, 1961 that (I) (we) last saw the deceased alive on 9/19, 1961 , and that death occurred at 12:00 P.M. from the causes and on the date stated above.							
22a. SIGNATURE L.B. STEVENS		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) L.B. STEVENS M.D.		22d. ADDRESS 3400 Erdman Ave - 13, Baltimore, Md.					
23a. BURIAL - CREMATION - REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 9/27/61		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home				ADDRESS 4210 Belair Rd. 6		25a. REC'D BY REGISTRAR SEP 26 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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COPIES OF THIS

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10004

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1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5635 Oakland Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residents before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u> d. STREET ADDRESS <u>5635 Oakland Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>A.</u> Last <u>Stiles</u>		4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1891</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>28</u>	
11. IF UNDER 24 HRS. Hours <u>9</u> Min. <u>58</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired glass worker</u>		14. KIND OF BUSINESS OR INDUSTRY <u>New Jersey</u>	
15. FATHER'S NAME <u>Isaac Stiles</u>		16. MOTHER'S MAIDEN NAME <u>Sarah White</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		18. SOCIAL SECURITY NO. (If yes give number or date of service) <u>Mrs. Elizabeth Stiles -5635 Oakland Road #27</u>	
19. INFORMATION Address <u>Mrs. Elizabeth Stiles -5635 Oakland Road #27</u>		20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> DUE TO (b) <u>Chr Myocarditis</u> DUE TO (c) <u>General Arterio Sclerosis</u> (e), stating the underlying cause last. <u>Arterio Sclerosis</u>	
21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		22. INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>1 yr</u> <u>5-78</u> <u>9-98</u>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
25a. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	26d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	27e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	28f. (City or town) (County) (State)
29. I certify that (I) (this hospital) attended the deceased from <u>Sept 27, 1961</u> to <u>Sept 27, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 27, 1961</u> , and that death occurred at <u>8:30</u> M. from the causes and on the date stated above.			
30a. SIGNATURE <u>B B Brumbaugh</u> M.D.		31. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 32. ADDRESS <u>1609 main st Elkridge</u>	
33a. PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>		34b. DATE SIGNED <u>9/27/61</u>	
35a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	36b. DATE THEREOF <u>8-30-61</u>	37c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>	38d. LOCATION (City, town or county) (State) <u>Elkridge, Maryland</u>
39. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Seakner & Sons</u>		40. ADDRESS <u>Nord - La. Balt. 17, Md.</u>	
41. REC'D BY REGISTRAR <u>SEP 29 '61</u>		42. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE c. LENGTH OF STAY IN 1b 7 YEARS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MASONIC HOME		2. USUAL RESIDENCE (Where deceased lived, if institution; name of place if not a mission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE d. STREET ADDRESS 1602 FREDERICK RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES W STODDARD		4. DATE OF DEATH Month SEPT Day 13 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-12-1866
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 95 yrs.
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME DANIEL STODDARD		14. MOTHER'S MAIDEN NAME MARY MYERS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Paul L. Smith Jr. - Cockeysville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio Vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) 7 years DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-2 , 1954, to 9-13 , 1961, that (I) (we) last saw the deceased alive on 9-13 , 1961, and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 9/13/61	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 16, 1961	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc.		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	
ADDRESS 1217 St. Paul St.		25a. REGISTRAR'S SIGNATURE SEP 15 1961	
DATE 15M 9/60		DATE	

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COOL, INC. 2317 St. Paul St.
Baltimore, Md.
JAN 10 1961

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN b. <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1222 Division Street - 17</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ASHEY - - STOOPS</u>		4. DATE OF DEATH Month Day Year <u>September 4 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1893</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (County & State, or foreign country) <u>Rockbridge Co. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Stoops</u>		14. MOTHER'S MAIDEN NAME <u>Mary MN: Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war/dates of service) <u>Yes WW-1</u>		16. SOCIAL SECURITY NO. <u>218-05-6853</u>	
17. INFORMANT <u>Clinical Records, VA Hospital, 3900 Loch Raven Blvd. Balto 18, Md-FORT HOWARD DIV.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRRHOSIS OF LIVER</u> <u>581.0 XXX</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRONCHOPNEUMONIA</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>1 DAY +</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. _____ 19____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) _____
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 25, 1961</u> to <u>September 4, 1961</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Sept. 4, 1961</u> , and that death occurred at <u>P.M.</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Sebastian Russo</u>		22b. DATE SIGNED <u>9/5/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>SEBASTIAN RUSSO, M.D.</u>		22d. ADDRESS <u>VAH, BALTO 18, MARYLAND, FT. HOWARD DIVISION</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>SEPT. 8, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore 28, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Holland Fun. Home, Balto. 17 Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 7 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>		25c. DATE _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS A15 (2)
15R 9160

VR A15 (4)
15M 9/60

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VAR. BATED 18, NATHANIEL T. HOWARD DIVISION

GERALD H. B. D.

Partial 2011/101 Baltimore National Cemetery Baltimore, Md. Maryland

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CHURCH OF LIVING

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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10007
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 8 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3. NAME OF DECEASED First Margaret Middle Agatha Last Sughrue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice		d. STREET ADDRESS 5213 Biddison Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month Sept. Day 12 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/13/1876
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 85 Days 85 Hours 85 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Sughrue		14. MOTHER'S MAIDEN NAME Margaret Murphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Admission Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Exhaustion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia (c) ASCD		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 5:15 A.M. to Sept. 12 1961 that (I) (we) last saw the deceased alive on Sept. 9 1961 , and that death occurred at 5:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert J. Mahon		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Robert J. Mahon, M.D.		22d. ADDRESS 602 E. Joppa Rd. Towson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/15/61	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town, or county) (State) BALTIMORE Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Konrad J. Rude		25a. REC'D BY REGISTRAR SEP 20 1961	
25b. REGISTRAR'S SIGNATURE S. J. Rude		25c. DATE	

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			c. LENGTH OF STAY IN 1b Life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9240 Smith Avenue				d. STREET ADDRESS 9240 Smith Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Samuel Middle S Last Tagg				4. DATE OF DEATH Month 9 Day 23 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-25-1859		9. AGE (In years last birthday) 101 yrs.	IF UNDER 1 YEAR Months 101 Days 9 Hours 23 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York NY		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Ethelbert Tagg				14. MOTHER'S MAIDEN NAME Elizabeth Stallings			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-14-8864		17. INFORMANT Mrs Naomie Wright Address 9240 Smith Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) dissecting (c)							INTERVAL BETWEEN ONSET AND DEATH 7
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1952 to Sept. 1961 , that (I) (we) last saw the deceased alive on Aug 1961 , and that death occurred at 11:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE Elliot Harris				22b. DATE SIGNED 9/25/61		22c. PHYSICIAN'S NAME (Type) Dr Elliot Harris	
22d. ADDRESS 8150 Harford Rd., Balto. 14, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-27-1961		23c. NAME OF CEMETERY OR CREMATORY Hiss Meth Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore 6 Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home				ADDRESS 7401 Belair Road		25a. REC'D BY REGISTRAR DATE SEP 26 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 13 Film G295 9/18/61 iwk

CERTIFICATE OF DEATH

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Reg. Dist. No.

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1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN 1b <u>15 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4458 BEARSHIRE</u>				d. STREET ADDRESS <u>17458 BEARSHIRE RD.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMILE J. THIBAUT</u>				4. DATE OF DEATH Month Day Year <u>9 8 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>JAN. 13, 1898</u>		9. AGE (In years last birthday) yrs. <u>63</u>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>METAL WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARTIN CO</u>		11. BIRTHPLACE (State or foreign country) <u>AMESBURY MASS.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>XAVIER Thibault</u>			
14. MOTHER'S MAIDEN NAME <u>MARIE LEVEQUE</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>517-10-3333</u>		17. INFORMANT Address <u>LORETTE THIBAUT (AS ABOVE)</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GI Hemorrhage</u> <u>5810</u> DUE TO (b) <u>Esophageal varices</u> (c) <u>Cirrhosis of liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>9/6</u> , 19 <u>52</u> , to <u>9/8</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>9/6</u> , 19 <u>61</u> , and that death occurred at <u>7 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>434 Eastern Ave</u>		DATE SIGNED <u>9/8/61</u>			
PHYSICIAN'S NAME (Type) <u>J. P. LATT, M.D.</u>		22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>					
22b. DATE THEREOF <u>9/13/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART OF JESUS</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>1005 DUNDALK AV.</u>		24a. REC'D BY REGISTRAR <u>SEP 11 61</u>			
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No.

10010

10003

MEDICAL CERTIFICATION

1. The first step in the process of the investigation of a disease is the collection of data. This is done by the use of questionnaires, interviews, and other methods. The data collected are then analyzed and interpreted. The results of the analysis are then used to determine the cause of the disease and to develop methods of prevention and control.

2. The second step in the process is the identification of the cause of the disease. This is done by the use of epidemiological methods, such as the study of the distribution and spread of the disease. The results of the study are then used to determine the cause of the disease and to develop methods of prevention and control.

3. The third step in the process is the development of methods of prevention and control. This is done by the use of epidemiological methods, such as the study of the distribution and spread of the disease. The results of the study are then used to determine the cause of the disease and to develop methods of prevention and control.

4. The fourth step in the process is the implementation of the methods of prevention and control. This is done by the use of epidemiological methods, such as the study of the distribution and spread of the disease. The results of the study are then used to determine the cause of the disease and to develop methods of prevention and control.

5. The fifth step in the process is the evaluation of the methods of prevention and control. This is done by the use of epidemiological methods, such as the study of the distribution and spread of the disease. The results of the study are then used to determine the cause of the disease and to develop methods of prevention and control.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTO. 10011 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 400 OAK COURT		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MD. b. COUNTY BALTO. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE d. STREET ADDRESS 400 OAK COURT e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DOROTHEA C. THOMPSON		4. DATE OF DEATH Month SEPT. Day 10 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 17, 1921
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months 40 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ESTIMATOR		12b. KIND OF BUSINESS OR INDUSTRY PRINTING CO.	
13. FATHER'S NAME GERALD E. COURTNEY		14. MOTHER'S MAIDEN NAME DOROTHY SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT William H. Thompson - 400 Oak Court		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast with metastases 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u>, 19<u>61</u>, to <u>Sept 10</u>, 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>August 30, 1961</u>, and that death occurred at <u>6 AM</u>, from the causes and on the date stated above.			
22a. SIGNATURE JOHN A. NESBITT, JR.		22b. DATE SIGNED 11/8 St Paul St, Baltimore 2, Md.	
22c. PHYSICIAN'S NAME (Type) JOHN A. NESBITT, JR.		22d. ADDRESS 1118 St Paul St, Baltimore 2, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 13, 1961	23c. NAME OF CEMETERY OR CREMATORY Levitt Ridge Cem.	23d. LOCATION (City, town or county) (State) Catonsville Md.
24. FUNERAL DIRECTOR'S SIGNATURE Forley, Cronough & F.A. - Catonsville, Md.		25a. REC'D BY REGISTRAR DATE SEP 14 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2019 Hillcrest Road		d. STREET ADDRESS 2019 Hillcrest Road	
3. NAME OF DECEASED (Type or print) Mildred Harvey Thomsen		4. DATE OF DEATH Month September Day 10 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-3-1901
9. AGE (In years lost birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steongrapher		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Oln ey, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William W. Harvey		14. MOTHER'S MAIDEN NAME Macie Pricw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-24-1713	
17. INFORMANT Jes Hygum Thomsen		Address 2019 Hillcrest Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of ribs, left lung & pelvis 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of left breast DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 mos. 3 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/7 , 19 59 , to 9/10 , 19 61 , that I last saw the deceased alive on 9/8 , 19 61 , and that death occurred at 6:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4111 Liberty Heights, Bk Baltimore 9/4/61 DATE SIGNED ACTUAL SIGNATURE Robert J. Schochat M.D. PHYSICIAN'S NAME (Type) Robert J. Schochat M.D. 1300 2nd			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/13/61	22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery	22d. LOCATION (City, town, or county) (State) Olney, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost ADDRESS Ellsworth Armacost 4600 Liberty Heights Ave.		24a. REC'D BY REGISTRAR DATE SEP 13 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other person is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10013 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balt City</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Balto</i>				3. VOl-4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Brent Tinsing Home</i>						d. STREET ADDRESS <i>4010 Clifton Ave - Balto 16</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>JOHN</i> Middle <i>TILGHMAN</i> Last <i>TILGHMAN</i>						4. DATE OF DEATH Month <i>Sept</i> Day <i>21</i> Year <i>1961</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Colored</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <i>1879</i>		9. AGE (in years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR Months <i>8</i> Days <i>2</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Butler</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Tilghman</i>						14. MOTHER'S MAIDEN NAME <i>Catherine Paraway</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <i>Brent Tinsing Home - Reisterstown</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia (Bilateral)</i> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <i>arteriosclerotic C.V. Disease</i> (c)										INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Fracture left hip.</i>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				21b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell down steps</i>							
22a. TIME OF INJURY Month, Day, Year Hour a.m. <i>5-3</i> p.m. <i>1961</i>				22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town) <i>Baltimore</i>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>D.D. Caples</i>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>9-21-61</i>			
EXAMINER'S NAME (Type) <i>D.D. CAPLES</i>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-25-61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt Auburn Cem</i>				22d. LOCATION (City, town, or country) (State) <i>Baltimore, Md.</i>			
23. FUNERAL DIRECTOR <i>Mrs. Francis T. Hensley</i>				ADDRESS <i>576 W. Biddle St.</i>				24a. REC'D BY REGISTRAR DATE <i>SEP 25 '61</i>		24b. REGISTRAR'S SIGNATURE <i>C. L. S. Hensley</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
10014 CERTIFICATE OF DEATH 10007															
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon c. LENGTH OF STAY IN 1b 10 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Worthington Hill				2. USUAL RESIDENCE (Where deceased lived, If institutional residence, before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon d. STREET ADDRESS Worthington Hill e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Carrie Miller Tovell				4. DATE OF DEATH Sept. 19, 1961				5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH June 21, 1873 9. AGE (In years last birthday) 88 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Henry Miller				14. MOTHER'S MAIDEN NAME Sarah Algire				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs. Helen Tovell Reese, Glyndon, Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Myocardial decompensating (c) Coronary Insufficiency PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Sudden year year				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-17-1961 to 9-19-1961 , that (I) (we) last saw the deceased alive on 9-17-1961 , and that death occurred at 4P M. from the causes and on the date stated above.															
22a. SIGNATURE James G. Siffell M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 9-21-61							
22c. PHYSICIAN'S NAME (Type) James G. Siffell MD				22d. ADDRESS Reisterstown Md											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Sept. 22/61				23c. NAME OF CEMETERY OR CREMATORY All-Saints				23d. LOCATION (City, town or county) (State) Reisterstown, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.				ADDRESS				25a. REC'D BY REGISTRAR SEP 25 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

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[Faint, illegible handwritten text, possibly a signature or address, spanning the bottom half of the page.]

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3. VITAL STATUS 3501-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines				d. STREET ADDRESS 2516 Washington Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Tschaksts (also John Schack)		First Middle Last		4. DATE OF DEATH Sept. 10, 1961		Month Day Year	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 17, 1872	
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired grocer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Latvia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Arnold E. Schack		Address 1601 Rolling Rd. #27	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4-22-61 IMMEDIATE CAUSE (a) Terminal bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CVD with DUE TO (c) cerebral thrombosis and hemiparesis		INTERVAL BETWEEN ONSET AND DEATH 3 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 1961 to Sept 10, 1961 , that (I) (we) last saw the deceased alive on 9/10/61 , and that death occurred 12:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Herbert J. Levickas		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Herbert J. Levickas, M.D.		22d. ADDRESS 5305 East Drive, Balto. 27, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/13/61		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue		25a. REC'D BY REGISTRAR SEP 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mercy Villa 6400 Bellona Avenue</u>				2. USUAL RESIDENCE (Where deceased lived, If institutional, last 10 days prior to admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>Blackstone Apts 3215 North Charles</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <u>Alice M. Tucker</u>		4. DATE OF DEATH Month <u>September</u> Day <u>22</u> , Year <u>1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 16, 1881</u>		9. AGE (In years last birthday) <u>80</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? 													
13. FATHER'S NAME <u>Charles Merritt</u>				14. MOTHER'S MAIDEN NAME <u>Kate Lynch</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u>													
17. INFORMANT <u>Mr. John M. Tucker</u>				Address <u>80 Hance Road Fair Haven N.J.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>Cerebral Hemorrhage</u> (b) <u>Arterio-sclerosis</u> DUE TO <u>Myocarditis</u> (c) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)											
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1, 1961</u> to <u>Sept 22, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 22, 1961</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.																					
22a. SIGNATURE <u>W. H. Woody</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 															
22c. PHYSICIAN'S NAME (Type) <u>Dr. W. H. Woody</u>						22d. ADDRESS <u>140 3rd Ave Baltimore 17 Md</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>9/25/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>				23d. LOCATION (City, town or county) <u>Pikesville, Md.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Tucker Son</u>						25a. REC'D BY REGISTRAR DATE <u>SEP 26 '61</u>															
25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>																					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 17 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Queen Annes c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Centreville d. STREET ADDRESS 208 Tillman Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IRA		4. DATE OF DEATH Month September Day 13 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 3, 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Aircraft	11. BIRTHPLACE (County & State, or foreign country) Centreville, Maryland
13. FATHER'S NAME Samuel Unsworth		14. MOTHER'S MAIDEN NAME Alice MN: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 579-07-7829	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CARCINOMA OF TRANSVERSE COLON, POST OPERATIVE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation-9/13/61-Laparotomy, Small Bowel Resection and Entero-anastomosis	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 27, 1961 , to September 13, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 13, 1961 , and that death occurred at 11:25 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Crahan M.D.		22b. DATE 9/13/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 9-16-61	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d. LOCATION (City, town or county) (State) Arlington 11, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.		25a. REGISTRY SIGNATURE SEP 18 1961	
25b. REGISTRAR'S SIGNATURE Arthur S. Krause			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Shipped to W. W. Chambers, Chapin St., Washington D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutions Residing prior to admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Training School		d. STREET ADDRESS none	
3. NAME OF DECEASED (Type or print) Warren Benjamin Wade		4. DATE OF DEATH Month 9 Day 28 Year 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/18/49
9. AGE (In years last birthday) 11 yrs.		IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.	IF UNDER 24 HRS. Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependent		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (County & State, or foreign country) Charles Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Benjamin Wade, Jr.	
14. MOTHER'S MAIDEN NAME Irma Marie Chapman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. ---		17. INFORMANT Rosewood Records, Owings Mills, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia due to undetermined cause (361.410) DUE TO (b) Anaurotic familial idiocy, Juvenile (902.9552) DUE TO (c) 11 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 9 a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 9/23 , 19 59 , to 9/28 , 19 61 , that (1) (we) last saw the deceased alive on 9/28 , 19 61 , and that death occurred at 10:45 p.m. on the date stated above.			
22a. SIGNATURE Grange A. Coffin		22b. DATE SIGNED 9-29-61	
22c. PHYSICIAN'S NAME (Type) Grange A. Coffin, M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/2/61	23c. NAME OF CEMETERY OR CREMATORY Church am.	23d. LOCATION (City, town or county) (State) Bryantown Charles Co md
24. FUNERAL DIRECTOR'S SIGNATURE Rev. B. Nelson		25a. REC'D BY REGISTRAR DATE OCT 2 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Frank			

11001

81001

(M)

(1)

Department of Agriculture

Office of the Secretary

Washington, D.C.

February 1, 1950

Dear Sir:

Very truly yours,

1/1
1/1
1/1

CERTIFICATE OF DEATH

Reg. Dist. No.

1001S

10012

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Middletown Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Graft Edward Walker</u>		4. DATE OF DEATH <u>Sept. 15, 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 20, 1876</u>
9. AGE (In years and birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Adam Walker</u>	
14. MOTHER'S MAIDEN NAME <u>Sarah Williams</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Joseph Walker, Freeland, Md. R.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH <u>60 hrs.</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> (c) <u>Arterio-sclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/22, 1961</u> to <u>9/15, 1961</u> that I last saw the deceased alive on <u>9/15, 1961</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		ADDRESS (Street, city or town, state) <u>PARTON, Md.</u> DATE SIGNED <u>9/16/61</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>9-18-61</u>	<u>Middletown Cemetery</u>	<u>Freeland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph H. Leutenstern, New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		DATE <u>SEP 19 61</u>	<u>Arthur L. France</u>

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5704

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 11 & 12 Film G295 9/18/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore M. STATE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Granite		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Granite	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bunker Hill		d. STREET ADDRESS Bunker Hill	
3. NAME OF DECEASED (Type or print) First MARY Middle JOHNSON Last WALKER		4. DATE OF DEATH Month Sept. Day 7 Year 1961	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1904
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 7 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Unknown Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Johnson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-24-2521	
17. INFORMANT Katie Hodge, Granite, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Arterial hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 hr INTERVAL BETWEEN ONSET AND DEATH ? ?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1928 to 9/7/61 , that I last saw the deceased alive on 9/5/61 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Randallstown Md DATE SIGNED SEP 11 '61			
ACTUAL SIGNATURE Wm. E. Martin		M.D. Randallstown Md	
PHYSICIAN'S NAME (Type) Wm. E. MARTIN		RANDALLSTOWN Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-11-61	
22c. NAME OF CEMETERY OR CREMATORY Cherry Hill		22d. LOCATION (City, town, or county) (State) Granite, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE SEP 11 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kins			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1880



I, J. J. [illegible]

I, J. J. [illegible]

I, J. J. [illegible]

I, J. J. [illegible]

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[Faint, illegible handwritten text]

[Faint, illegible handwritten text]

I, J. J. [illegible]

I, J. J. [illegible]

I, J. J. [illegible]

I, J. J. [illegible]

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 10021
 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Holbrook		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Holbrook	
c. LENGTH OF STAY IN 1b 17 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Liberty Rd. Randallstown P.O.		d. STREET ADDRESS Liberty Rd. Randallstown P.O.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Roland Last Walsh		4. DATE OF DEATH Month Sept. Day 16 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1892
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Grocery	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Walsh		14. MOTHER'S MAIDEN NAME Mary Jane Wills	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-05-1443	
17. INFORMANT Mrs. Bernice G. Walsh		Address Liberty Rd. Holbrook Randallstown, P.O., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Rupture of Aneurysm of Abdominal Aorta (b) Arteriosclerosis (c) 20 min Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1955 to 9/16/1961 , that (I) (we) lost saw the deceased alive on 9/16/1961 , and that death occurred on 9/16/1961 , from the causes and on the date stated above.			
22a. SIGNATURE Dr. Wm. E. Martin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Wm. E. Martin		22d. ADDRESS Liberty Rd. Harrisonville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-19-61	
23c. NAME OF CEMETERY OR CREMATORY Hereford Baptist Ch. Cem.		23d. LOCATION (City, town, or county) (State) Hereford, Balto. C., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Spring Byers		25a. REC'D BY REGISTRAR DATE SEP 21 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10022

10015

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3V01-4</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>316 N. Poppleton St. - 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>S.A. ARTHUR</u> <u>ARTHUR</u> <u>I</u>		4. DATE OF DEATH Month <u>September</u> Day <u>16</u> Year <u>19 61</u> <u>WATERS</u> <u>WATERS</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 25, 1894</u> <u>67</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick, Maryland</u>	
13. FATHER'S NAME <u>Newton Waters</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u> <u>WW-1</u>		17. INFORMANT <u>Clinical Records, VA Hospital</u> <u>Baltimore 18, Maryland-FORT HOWARD DIVISION</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLUS, RIGHT</u> Conditions, if any, which gave rise to immediate cause (b) <u>ATELECTASIS, CHRONIC, LEFT</u> (c) <u>HYPERTROPHIED LEFT VENTRICLE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>Unknown</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>he</u> (this hospital) attended the deceased from <u>Sept. 14, 1961</u> , to <u>Sept. 16, 1961</u> , that <u>he</u> (we) last saw the deceased alive on <u>Sept. 16, 1961</u> , and that death occurred at <u>1:10 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Donald W. Stewart</u>		22b. DATE SIGNED <u>9/16/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>DONALD W. STEWART, M.D.</u>		22d. ADDRESS <u>VAH Baltimore 18, Md.</u> <u>Fort Howard Division</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-19-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore</u> <u>Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy O. Wilson</u>		25a. REC'D BY REGISTRAR <u>SEP 27 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>			

MEDICAL CERTIFICATION

10012

10012

(M)

(I)

10-10-9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10023

CERTIFICATE OF DEATH

10016

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b 52 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jacksonville Baltimore 15			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1305 Malbay Drive				d. STREET ADDRESS 5631 Reisterstown Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Russell Middle Wedge, Sr. Last Wedge, Sr.				4. DATE OF DEATH Month Sept. Day 22, Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 18, 1884	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 77 Days 77		IF UNDER 24 HRS. Hours 77 Min. 77			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Money Room		10b. KIND OF BUSINESS OR INDUSTRY Par Mutuals Race Track		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Wedge				14. MOTHER'S MAIDEN NAME Florence McClure			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-10-7379		17. INFORMANT Mr. Robert R. Wedge			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 260X DUE TO Conditions, if any, which gave rise to immediate cause (b) arteriosclerosis (c) Diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X				INTERVAL BETWEEN ONSET AND DEATH 3 days 7 7			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 9/20 , 19 61 , to 9/22 , 19 61 , that (1) (we) last saw the deceased alive on 9/22 , 19 61 , and that death occurred at 11:50 PM , from the causes and on the date stated above.							
22a. SIGNATURE George T. Gilmore M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) George T. Gilmore, M.D.				22d. ADDRESS Lanham Building Lutherville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-26-61		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers				25a. REC'D BY REGISTRAR SEP 25 '61		25b. REGISTRAR'S SIGNATURE Arthur J. Kenna	

VR A15 (4)
15M 9/60

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213-10-1073 . 2 . Robert A. Wingo

• but : different

Learning History

George F. Clinton, Jr.

13-05-9 10194

1957-1958
1959-1960

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other person is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10024 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10017									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Garrison</u> c. LENGTH OF STAY IN 1b <u>2½ mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Foxleigh Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3104 Brightwood Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>MATILDA</u> Middle <u>E.</u> Last <u>WEISS</u>					4. DATE OF DEATH Month <u>September</u> Day <u>1</u> Year <u>1961</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 15, 1898</u>		9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Keaton Rubber Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Eichner</u>					14. MOTHER'S MAIDEN NAME <u>Rebecca Ziegler</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>139-20-7892</u>		17. INFORMANT <u>Mr. Sheldon G. Weiss-3104 Brightwood Avenue</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Carcinomatosis</u> DUE TO (b) <u>Ca. Rt. Breast with Metastasis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (c) <u>Radiation burns chest & back</u> <u>Ca. Left Breast with Mastectomy</u> INTERVAL BETWEEN ONSET AND DEATH <u>3½ yrs.</u> <u>3 yrs.</u> <u>6 mos.</u> <u>3½ yrs.</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Osteoarthritis, Fract. neck Rt. Femur</u>				20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>fell out of bed at home</u>					
20c. TIME OF INJURY Month, Day, Year <u>6-7</u> <u>hour</u> <u>a.m.</u> <u>Feb. 8, 1961</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Newark</u> <u>N.J.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>D.D. Caples</u> EXAMINER'S NAME (Type) <u>D. D. Caples, M. D., 6 Hanover Rd. Reisterstown, Md.</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>9-1-61</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Removal</u>		22b. DATE THEREOF <u>9-1-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beth David Corp.</u>		22d. LOCATION (City, town, or country) (State) <u>Union County, New Jersey</u>			
23. FUNERAL DIRECTOR ADDRESS <u>Sol. Levinson & Bros. Inc., 6010 Reist. Road</u>						24a. REC'D BY REGISTRAR DATE <u>SEP 5 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

10002
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10002

10002 MEDICAL EXAMINATION CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

IN THE CITY OF BOSTON, COUNTY OF SUFFOLK, STATE OF MASSACHUSETTS, on the _____ day of _____, 19____, at _____, in the City of Boston, County of Suffolk, State of Massachusetts, I, _____, a duly qualified and licensed physician, have examined the body of _____, deceased, and find that the cause of death was _____, and that the death was due to natural causes.

Witness my hand and seal this _____ day of _____, 19____.

Physician

City and County

State

Signature of Physician

Signature of City and County

Signature of State

Signature of City and County

Signature of State

Signature of City and County

Signature of State

Signature of City and County

Signature of State

Signature of City and County

Signature of State

Signature of City and County

Signature of State

Signature of City and County

Signature of State

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10025

CERTIFICATE OF DEATH

10018

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>1120 Arran Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1120 Arran Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mrs. Louisa D. Wells</u>		4. DATE OF DEATH Month <u>September</u> Day <u>5</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct, 6, 1883</u>			
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Ferdinand A. Annreich</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Johnston</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Mrs. Ida Scott 1120 Arran Rd. #4</u>			
17. INFORMATION <u>Mrs. Ida Scott 1120 Arran Rd. #4</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Acute Terminal congestive heart failure</u> DUE TO (c) <u>myocardial insufficiency & Angina Pectoris</u> <u>Arteriosclerotic Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) <u>Leonard H. Flax, M.D.</u> attended the deceased from <u>9/4</u> , 19 <u>61</u> , to <u>9/5</u> , 19 <u>61</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>9/4</u> , 19 <u>61</u> , and that death occurred at <u>2:50 PM</u> from the causes and on the date stated above		22a. SIGNATURE <u>Leonard H. Flax, M.D.</u>			
22c. PHYSICIAN'S NAME (Type) <u>Leonard H. Flax, M.D.</u>		22d. ADDRESS <u>1202 St. Paul St. #2</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/8/61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard E. Ruck 5305 Harford Road #14</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 8 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>					

10018

10018



Leonard G. Allen 2302 Madison Road #14

Booked

Forwarded New York

Received by Special Agent

is necessary,
director. Page
ained for your files.
ate Board of Health,
th.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

1. PLACE OF DEATH a. COUNTY BALTO		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDACK		c. LENGTH OF STAY IN 1b 35 YRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1807 SNYDER AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH ALEXANDER WHEELKLY		4. DATE OF DEATH Month SEPT. Day 9 Year 1961	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH APR. 12, 1886	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 7 Days 1	
11. IF UNDER 24 HRS. Hours 1 Min. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALEXANDER WHEELKLY		14. MOTHER'S MAIDEN NAME LOUISIE WILSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-05-5144	
17. INFORMANT WELLIE WINEHOLT WHEELKLY		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) A-S-C-V-DISEASE (c) A-S-C-V-DISEASE		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. DAVIS MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9/11/61	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/13/61	
22c. NAME OF CEMETERY OR CREMATORY MORELAND MEM.		22d. LOCATION (City, town, or country) (State) BALTO. MD	
23. FUNERAL DIRECTOR Walter Rupp Roddy, Hurdock		24a. REC'D BY REGISTRAR SEP 13 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

10001

M

1/1/12

W. J. Davis

Black Oak, Kentucky, the last day of

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before institution) a. STATE <u>Maryland</u> b. COUNTY <u>3501-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Baltimore</u>		c. LENGTH OF STAY IN 1b <u>3 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Robb Nursing Home 4105 Essex Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Zelona M. Whitcraft</u>		4. DATE OF DEATH <u>Sept. 25, 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1877</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>12</u> Hours <u>4</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Whitcraft</u>		14. MOTHER'S MAIDEN NAME <u>Lida Conway</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>RA Whitcraft, Parkton, Md. R.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>420.0</u> (c) <u>arteriosclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of tibia and fibula - compound</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Fall from ladder</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>June 1961</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Balto.</u> (County) <u>Md</u> (State)	
21. I certify that I attended the deceased from <u>June 19, 1961</u> to <u>Sept 25, 1961</u> , that I last saw the deceased alive on <u>Sept 25, 1961</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Heber Gundersen</u> M.D.		ADDRESS (Street, city or town, state) <u>Riviera Cpts Balto. 17</u> DATE SIGNED <u>9/25/61</u>	
PHYSICIAN'S NAME (Type) <u>A</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 28, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		22d. LOCATION (City, town, or county) <u>Stewartstown, Pa.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u> ADDRESS <u>New Freedom, Pa.</u>		24. REC'D BY REGISTRAR <u>SEP 29 '61</u> DATE	
25. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10050

1917

John J. Patterson, 3 years, 3 months, 3 days

of Baltimore, Maryland

born at Baltimore, Maryland, August 17, 1914

and died at Baltimore, Maryland, August 20, 1917

at the residence of his mother, Mrs. J. J. Patterson

at Baltimore, Maryland, at the age of 3 years, 3 months, 3 days

caused by a disease of the lungs

the result of a cold

the attending physician was Dr. J. J. Patterson

the funeral was held at the residence of the deceased

on August 21, 1917, at 10 o'clock A. M.

and was conducted by the Rev. J. J. Patterson

the interment was made in the cemetery at Baltimore

on August 21, 1917, at 11 o'clock A. M.

the burial was conducted by the Rev. J. J. Patterson

the funeral was held at the residence of the deceased

on August 21, 1917, at 10 o'clock A. M.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10028 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 1 & 9 Film G295 9/15/61 ink											
1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution, residence, or other admission)		10021			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Catonsville		c. LENGTH OF STAY IN 1b		a. STATE		Maryland		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Md. State Forest Reserve		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore		d. STREET ADDRESS		713 W. Lafayette Ave.	
3. NAME OF DECEASED (Type or print)		First CHARLES		Middle H.		Last WHITE		4. DATE OF DEATH		Month September 4 1961	
5. SEX		Male		6. COLOR OR RACE		Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8/15/99		9. AGE (In years last birthday)		62 63 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Laborer		10b. KIND OF BUSINESS OR INDUSTRY		Refinery & Smelting		11. BIRTHPLACE (State or foreign country)		Virginia	
13. FATHER'S NAME		Unknown		14. MOTHER'S MAIDEN NAME		Unknown		12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service)		No		16. SOCIAL SECURITY NO.		214-01-5063		17. INFORMANT		Genevieve	
								Address		713 W. Lafayette Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Arteriosclerotic cardiovascular disease		DUE TO		422.1		INTERVAL BETWEEN ONSET AND DEATH	
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO		(b)					
				DUE TO		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE		Howard Shaub		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		EXAMINER'S NAME (Type)		Howard Shaub, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/5/61	
22a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		22b. DATE THEREOF		9/9/61		22c. NAME OF CEMETERY OR CREMATORY		Mt. Auburn	
								22d. LOCATION (City, town, or country) (State)		Baltimore Md.	
23. FUNERAL DIRECTOR		Charles A. Rice		ADDRESS		661 W. Barre Street		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
								DATE SEP 13 '61		Arthur S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10029

10022

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 14 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22 d. STREET ADDRESS 79 Wise Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RAY Middle S. Last WILKERSON (Served as RAY S. WILKERSON)		4. DATE OF DEATH Month September Day 6 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/31/95
9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Fitter 10b. KIND OF BUSINESS OR INDUSTRY Shipping 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Wilkerson		14. MOTHER'S MAIDEN NAME Martha Forsythe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) WW I		16. SOCIAL SECURITY NO. 216-10-4048 17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, LEFT LUNG DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 14 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Emphysema, obstructive. Operation 1/27/61 Wedge biopsy, prescalene node / Epidermoid carcinoma			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug. 23, 1961 , to Sept. 6, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 6, 1961 , and that death occurred at 2:50 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Crahan M.D.		22b. DATE SIGNED 9/6/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-8-61	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	23d. LOCATION (City, town or county) Baltimore 28, Maryland (State) _____
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, MD.		25a. REC'D BY REGISTRAR SEP 8 '61	25b. REGISTRAR'S SIGNATURE - - - - -

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4

(M)

(I)

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pikesville		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 212 Church Lane, Pikesville, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hannah Middle Frances Last Wimsett		4. DATE OF DEATH Month Sept. Day 4, Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1877
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 4 Days 19 Hours 61	11. IF UNDER 24 HRS. Months 4 Days 19 Hours 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmaster		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Stevenson, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Henery Wimsett, Sr.		14. MOTHER'S MAIDEN NAME Mary Mertin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Margaret E. Wimsett, 212 Church Lane		18. Pikesville 8, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis - chronic DUE TO decompensating Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension DUE TO arteriosclerosis (c) INTERVAL BETWEEN ONSET AND DEATH 5 yrs 4 years 4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-1-42 to 9-4-61 , that (I) (we) last saw the deceased alive on 9-22-1961 , and that death occurred at 7:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE James G. Saffell		22b. DATE SIGNED 9-4-61	
22c. PHYSICIAN'S NAME (Type) James G. Saffell MD		22d. ADDRESS Reisters Town, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 7, 1961	23c. NAME OF CEMETERY OR CREMATORY St. Charles Church	23d. LOCATION (City, town, or county) (State) Pikesville 8, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		25a. REC'D BY REGISTRAR SEP 11 1961	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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al director. Page
4 for your files

TO DEF. / MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a
please execute the certificate, writing the word "pending" in pencil in Item 18. Give n. 1, 2, and 3 to it
4 should be forwarded to the Chief Medical Examiner's Office along with

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SM 7/5

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10031 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10024

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ORCHARD INN, JOPPA RD.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>3V44</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>3710 ELKHADER RD.</u>			
3. NAME OF DECEASED (Type or print) <u>GEORGE BERNARD YOUNG</u>				4. DATE OF DEATH Month <u>9</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 21 1906</u>	
9. AGE (In years last birthday) <u>54</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>19</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARTENDER</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>ORCHARD INN</u>		11. BIRTHPLACE (State of foreign country) <u>WASH. D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>ARTHUR V. YOUNG</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET GILCHRIST</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mrs. M.J. Young</u>				Address <u>3710 ELKHADER RD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO (b) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Sudden</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 Mins.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>9/21/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/25/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CATHEDRAL CEM</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO</u>	
23. FUNERAL DIRECTOR <u>NIEDEFELD & SON 501 E. 22ND ST.</u>				24a. REC'D BY REGISTRAR <u>SEP 26 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Frank</u>	

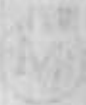
MEDICAL CERTIFICATION

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FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED BY THE DEPARTMENT OF HEALTH
AND HUMAN SERVICES
ON 10/10/68
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10031



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10032

10025

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1219 63rd St.</u>				2. USUAL RESIDENCE (Where deceased lived, If institutionalized, give address of residence) b. COUNTY <u>Baltimore</u> e. STATE <u>Md.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rosedale</u> d. STREET ADDRESS <u>1219 63rd St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary</u> First 5. SEX <u>female</u> Middle 6. COLOR OR RACE <u>white</u> Last 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>4-13-1896</u> 9. AGE (In years last birthday) <u>65</u> Month IF UNDER 1 YEAR: Months <u>Sept.</u> Days <u>30</u> Year <u>19 61</u> IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Greece</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> 13. FATHER'S NAME <u>Andrew Pyros</u> 14. MOTHER'S MAIDEN NAME <u>Arhontoula Vassilaros</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> 16. SOCIAL SECURITY NO. <u></u> 17. INFORMANT <u>Mrs James Mastrogeorge</u> Address <u>same</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Pulmonary Infarcts</u> 444X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension</u> (a), stating the underlying cause last. DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>		20c. TIME OF INJURY Month, Day, Year <u>19 61</u> Hour a.m. <u></u> p.m. <u></u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> 20f. (City or town) <u>Baltimore</u> (County) <u></u> (State) <u></u>					
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 5</u> , 19 <u>61</u> to <u>Sept 30</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Sept 30</u> , 19 <u>61</u> , and that death occurred at <u>3:55 A.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John B. Orth</u> 22c. PHYSICIAN'S NAME (Type) <u>JOHN B. ORTH</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>8019 Philad. Rd. Balto. Md.</u>		22b. DATE SIGNED <u></u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 23b. DATE THEREOF <u>10-2-1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Greek Cemetery</u> 23d. LOCATION (City, town or county) <u>Baltimore, Md.</u> (State) <u></u>		25a. REC'D BY REGISTRAR <u></u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u> DATE <u>OCT 3 '61</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

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Leonard J. Hall 2505 Maryland Ave.
N.W. Washington, D.C. 20007

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. **10026**

10033

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		c. LENGTH OF STAY IN 1b 40 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hillside Ave		e. STREET ADDRESS 1 Hillside Ave	
3. NAME OF DECEASED (Type or print) Walter Mason Zembower		4. DATE OF DEATH Month September Day 18 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1892
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Quarry	
11. BIRTHPLACE (State or foreign country) Everett Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Josiah Zembower		14. MOTHER'S MAIDEN NAME Sarah Jane Mortimer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Wife	
17. INFORMANT Wife		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Arteriosclerotic cardiac vascular disease DUE TO Coronary Insufficiency (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 or 8 minutes over 5 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 61 to Sept 61 , that I last saw the deceased alive on 14 Sept 61 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter T. Kees		DATE SIGNED 18 Sept 1961	
PHYSICIAN'S NAME (Type) WALTER T. KEES		ADDRESS (Street, city or town, state) Cockeysville Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF SEPT. 20, 1961	22c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial	22d. LOCATION (City, town, or county) (State) Cockeysville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Md.		24a. REC'D BY REGISTRAR SEP 28 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10034 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 11 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution, residence, or care admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 26 d. STREET ADDRESS 1610 Popland Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) FREDERICK C. ZIEMER				4. DATE OF DEATH Month September Day 26 Year 1961									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 13, 1897		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard				10b. KIND OF BUSINESS OR INDUSTRY Fruit Company				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Ziemer				14. MOTHER'S MAIDEN NAME Elizabeth Hohman				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 705-10-6485	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland				17. INFORMANT Fort Howard Division				17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland				17. INFORMANT Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTRO-INTESTINAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) LAENNEC'S CIRRHOSIS DUE TO (c) UNKNOWN										INTERVAL BETWEEN ONSET AND DEATH FEW HOURS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (X) (this hospital) attended the deceased from September 15 1961 to September 26 1961 that (X) (we) last saw the deceased alive on Sept. 26 1961 , and that death occurred at 10:00 A.M. from the causes and on the date stated above.													
22a. SIGNATURE SEBASTIAN RUSSO, M.D.				22b. DATE SIGNED 9/26/61				22c. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9-29-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Wm. S. Fialkowski				25a. REC'D BY REGISTRAR SEP 27 '61				25b. REGISTRAR'S SIGNATURE Arthur J. Kline					

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VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10035					10028						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY Baltimore					a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					b. COUNTY Prince George						
c. LENGTH OF STAY IN 1b 2yr10mth					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville, Maryland						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL					d. STREET ADDRESS 4500 Yates Road						
3. NAME OF DECEASED (Type or print) Margaret					4. DATE OF DEATH SEPT 28, 1961						
5. SEX female					6. COLOR OR RACE white						
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH Dec. 17, 1881						
9. AGE (In years last birthday) 79 yrs.					10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife					11. BIRTHPLACE (County & State, or foreign country) Germany						
12. CITIZEN OF WHAT COUNTRY? U. S. A.											
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) unknown					16. SOCIAL SECURITY NO. unknown						
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL					Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterioscl. Cardiovasc. Disease 422-1 DUE TO Arteriosclerosis, general, severe Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from Nov. 26, 1958 to 9/28, 1961, that (I) (we) last saw the deceased alive on 9/28, 1961, and that death occurred at 8:30 A.M. from the causes and on the date stated above.											
22e. SIGNATURE Stella Wachslar										22b. DATE SIGNED 9/28/61	
22c. PHYSICIAN'S NAME (Type) STELLA WACHSLER										22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Oct 2, 1961										23b. DATE THEREOF Oct 2, 1961	
23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery										23d. LOCATION (City, town, or county) Cleveland, Ohio	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers										25a. REC'D BY REGISTRAR DATE OCT 2 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Frame											

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RECEIVED
JAN 21 1964
U.S. AIR FORCE
HONOLULU, HAWAII